

**UNION ENDICOTT CENTRAL SCHOOL DISTRICT
Occupational Therapist Evaluation Form**

Name of **Employee** _____ **Date** _____

Position _____ **Location** _____

EVALUATION SUMMARY:

Job Performance (check one)

MEETS OR EXCEEDS EXPECTATIONS		NEEDS IMPROVEMENT*	
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**Needs improvement requires the attached growth plan be filled out with the employee.*

I have reviewed my evaluation along with my evaluator. My signature means that I have discussed my evaluation; it does not necessarily mean that I agree with the contents of this evaluation.

Any comments I desire to make regarding this evaluation will be submitted in writing and attached to this form.

Employee Signature _____ **Date** _____

Evaluated by _____ **Date** _____

Reviewed by _____ **Date** _____

EMPLOYEE RESPONSE (If additional space is needed, please attach a separate sheet)

Signature of Employee: _____

Date: _____

Employee Growth Plan

For employees deemed in need of improvement, the following identifies goals to be achieved, tasks, target dates and verification methods for an improvement plan. Said plan will be developed with the employee.

Goal:

Target Date:

Tasks/Verification:

Goal:

Target Date:

Tasks/Verification:

Goal:

Target Date:

Tasks/Verification: