New Employee Orientation Checklist

Employee's Name: _____ Date: _____

Check off ☒ that all of the procedures below were completed

☐ **Welcome employee to practice and start this orientation:**
- ☐ Tour the facility and introduce her to co-workers, giving names and positions.
- ☐ Show them where to store their personal belongings.
- ☐ Show the location of time card/time clock (if used), or how to account for their hours.
- ☐ Show them the staff-lounge/lunchroom (if it exists) and comment on its use.
- ☐ Show the location of the staff parking area.
- ☐ Tell the employee the name the doctor prefers to be called in front of patients.
- ☐ Explain the employee's relationship to their supervisor (if applicable).
- ☐ Have them read and sign the Office Policy Manual, indicating they agree to abide by it.

☐ **Initiate an Employee Personnel File:**
- ☐ Obtain a file folder (a patient records folder will probably do) and place the employee's name on it.
- ☐ Place the employee's Resume, Application forms, tests, etc. in the file folder.
- ☐ Have the entire 15 pages of the Employee Personnel & Medial Records printed out for her.

☐ **Enter employee's information on the "Personnel Records Summary" (page-2).**
- ☐ Document this employee's positions and salaries and exposure categories.
- ☐ Complete this employee's "W-4" federal tax form and state forms.
- ☐ Complete this employee's Employee Eligibility Verification (I-9) form.
- ☐ Review this employee's work positions (job descriptions) and training programs.
- ☐ Discuss CPR Certification, schedule it or file the card of their training.
- ☐ Complete the "Employee History in Case of Emergency" form (page-3).

☐ **Enter employee's information on the "Medical Records Summary" (page-4).**
- ☐ Complete and sign the "Acknowledgement of Category 1 & 2 Employee" form (page-5).
- ☐ Discuss and have them read and sign the "Hepatitis B Vaccine Acceptance/Refusal" (page-6).

☐ **Complete this employee's OSHA Training Programs within the next two days:**
- ☐ Refer to "The Environmental Safety Handbook" for training Workbook and Text.
- ☐ Category 1, 2 & 3: Hazard Communication Plan training completed and (page-7) form signed.
- ☐ Category 1, 2 & 3: Hazardous Waste Management Plan training completed and (page-7) form signed.
- ☐ Category 1 & 2: Bloodborne Pathogens Standards training completed and (page-8) form signed.
- ☐ Enter the OSHA 3-Month (page-9) and Periodic (page-10) performance appraisal dates.

☐ **Schedule this employee's Position Orientation and Training program.**
- ☐ Refer to "The Orthodontic Text" and Workbook for her orthodontic orientation training.
- ☐ Schedule her position training using the "Team Member Training Manual" procedures.

☐ Other: _____

Name of Employer:_____

Name of Trainer: _____

Signature of Trainer: _____ Date: _____

Employee PERSONNEL Records Summary

Practice Name: _____ Phone: _____

Practice Address:_____

Employee's Name: _____ Date of Birth:_____

Address: _____ Date of Hire: _____

Social Security #: _____-_____-_____ Home Phone: _____

Email Address: _____ Cell Phone: _____

Employee Hiring Enclosed Records

Forms Signed and Materials Enclosed:

- ☐ Cover Letter ☐Resume ☐Hiring Questionnaire (application form) ☐Other:_____
- ☐ Employee Emergency History (page-3) ☐W-4 ☐1-9 _____
- ☐ Signature page acknowledging that she read and agrees to the Office Policy Manual
- ☐ Completed Orientation Checklist (page-1)

Position(s) Employee Hired for: ☐Clerical Coordinator ☐T.C. ☐Recep ☐Bkkpr ☐Sec ☐Clinical Coordinator ☐E.S.C. ☐Clinical Asst. ☐Rec. Tech ☐Clinical Aide ☐Lab Tech

Category: ☐1 ☐2 ☐3 ► ☐Acknowledgement of Exposure Category signed/enclosed (page-5)

Initial Salary Agreements:

- ☐ Starting Salary of $_____/hour on Date:_____
- ☐ Salary increase of $_____/hour after ☐3 ☐6 _____ months

Position & OSHA Training and Evaluations Enclosed Records

☐ Initially trained in the _____position ☐ CPR Training on (date_____)

☐ Hazard Communication/waste Training (date_____) ☐Page-7 Completed/Signed

☐ Bloodborne Pathogens Training (date_____) ☐Page-8 Completed/Signed

☐ 3-Month Compulsory, Employee OSHA Self-Evaluation, completed on (date_____)

☐ OSHA Periodic Evaluation Dates: _____ _____ _____ _____

☐ End of Conditional Employment Period: (Date_____): ☐Acceptable ☐NOT Acceptable

Termination of Employee Records Enclosed

☐ Disciplinary WARNING (page-?) dates: _____ _____ _____ _____ _____

☐ Disciplinary ACTION (page-?) dates: _____ _____ _____ _____ _____

☐ Notice of Voluntary Termination (page 4) signed/enclosed ☐Yes ☐Fired

☐ Warning / Action documentation enclosed if employee was fired? ☐Yes _____

☐ Exit Interview Questionnaire signed/enclosed (page 15) ☐Yes ☐No

Employee History in Case of Emergency

Practice Name: _____ Date:_____

Employee's Name: _____ Home Phone:_____

In Case of Emergency, Notify: _____

Relationship to Employee: _____

Person's Home Phone: _____ Person's Work Phone: _____

Preferred Hospital: _____ Branch: _____

Preferred Physician: _____ Office Phone: _____

Pertinent Medical History:

Medication Allergies/ Reactions: _____

Non-Medication Allergies: _____

Chronic Disease: ☐Epilepsy ☐Diabetes ☐Heart Trouble ☐Other _____

Does employee wear a Medical Alert? ☐No, If ☐Yes, for _____

Other comments on employee's medical history: _____

_____

_____

Exposure 1 or 2 Employees; date of hepatitis B vaccination: _____

Other Immunizations (date & type): _____

_____

Acknowledgement:

I certify that the above information is correct and can be used in case I require emergency assistance and I will notify this practice if there are any changes in the future.

Employee Signature: _____ Date:_____

I, as ☐doctor or ☐supervisor of this employee, have discussed the above information and find it to be accurate.

Signature: _____ Date:_____

Employee MEDICAL Records Summary

Practice Name: _____ Phone: _____

Employee's Name: _____

Employee's Work Position(s): ☐T.C. ☐Receptionist ☐Bookkeeper ☐Secretary
☐Environmental Safety Coordinator ☐Clinical Assistant
☐Records Tech ☐Lab Tech ☐Other:_____

Employee's Exposure Category: ☐1 ☐2 ☐3 on date hired. Date Hired: _____

Record of Hepatitis B Vaccinations (see page-5)

☐ Hepatitis B Vaccine Acceptance/Refusal form read, understood, signed and a copy enclosed.

☐ Vaccine: Accepted Refused (Reason) _____

☐ Employee medical records regarding ability to receive this vaccine: ☐Enclosed ☐N.A.

The series of three injections were scheduled/received on the following **dates**:

(scheduled.) _____/_____ (injected) (scheduled.) _____/_____ (injected)

(scheduled.) _____/_____ (injected) (scheduled.) _____/_____ (injected)

☐ Adverse Reactions to Vaccine? ☐None _____

☐ Antibody Testing to 1st Series on (date) _____, Results = + - _____

☐ A second series of injections were scheduled/received on the following dates: ☐N/A

(scheduled.) _____/_____ (injected) (scheduled.) _____/_____ (injected)

(scheduled.) _____/_____ (injected)

☐ Antibody Testing to 2nd Series on:(date) _____, Results = + - _____

☐ 5-Year Antibody Testing: (date) _____ + - (date) _____ + - (date) _____ + -

☐ Other: _____

Record of Accidents/Exposures to Bloodborne Pathogens (see pages)

Enter Date and Check off the boxes ☐ for the Records Enclosed.

Date _____ ☐Page-11 E/A Report ☐Page-12 Incident Report ☐OSHA form #200 Physician report

Date _____ ☐Page-11 E/A Report ☐Page-12 Incident Report ☐OSHA form #200 Physician report

Date _____ ☐Page-11 E/A Report ☐Page-12 Incident Report ☐OSHA form #200 Physician report

Date _____ ☐Page-11 E/A Report ☐Page-12 Incident Report ☐OSHA form #200 Physician report

Acknowledgement of Category 1 & 2 Employees

Practice Name: _____ Date:_____

Employee's Name: _____ Position: _____

Employees categorized by potential exposure to bloodborne pathogens:

Category 1 All occupations that require procedures or occupation-related tasks that involve direct exposure or the potential for exposure to blood or other potentially infectious material, or that involve a potential for spills or splashes of blood or other potentially infectious material. This includes procedures or tasks, which are a condition of employment for a job classification and are conducted on a routine and non-routine basis.

Category 2 Occupations that require tasks that do NOT involve direct exposure to blood or other potentially infectious material on a routine or non-routine basis as a condition of employment.

Category 3 Occupations that do not require tasks that involve potential for exposure to blood or other potentially infectious material on a routine or non-routine basis as a condition of employment. Employees in occupations in this category do not perform or assist in emergency patient care and are not potentially exposed in any other way.

Dentistry has been required in the past several years to adopt and practice the requirements of several regulatory agencies, particularly OSHA. I, as your employer, will be required to enforce observance of the regulations by you. You, as my employee, will be required to comply with all applicable regulations and will be required to participate in all training sessions describing these regulations. It is important that you fully understand the requirements for the position(s) you are hired for. If you do not fully comprehend any procedures, you will be urged to seek clarification. Your safety will depend on your understanding and practice of the procedures relative to your work position(s).

We provide Exposure Category 1 and 2 employees (OSHA's description of employees who may become exposed to bloodborne pathogens) with Personal Protective Equipment (PPE), at no cost to you. PPE includes gloves, masks, eye protection, gowns and other such equipment which may be necessary to perform your tasks. OSHA requires that all Category 1 and 2 employees wear PPE, unless an extraordinary occurrence precludes use of the items. If an employee chooses to not wear an item of personal protection, he/she will be required to secure a letter from his/her physician stating the reason why that particular PPE cannot be utilized. After reviewing the physician's request, I can exempt the employee from wearing that item for the time specified, as long as that employee's safety and/or the safety of others, will not be impaired by the exemption. If I feel that safety will be impaired, the employee will not be allowed to practice without the use of the PPE. If this is the only recourse, and if no other position in the practice is open, the employee may be required to use sick leave and/or vacation time until the reason for the request is corrected. In isolated instances, for example, development of serious irreversible allergy to the equipment, the employee may be required to resign his/her position without prejudice to my office. Please understand that this policy is necessitated by my dedication to provide the safest workplace for my employees.

Employee Agreement

I certify that I have read the above conditions for my employment here and that I fully understand each statement therein. I further understand that I work in a Category 1 or 2 position. I accept and will abide by the conditions above.

Employee's Signature: _____ Date:_____

Doctor/Supervisor's Signature: _____ Date:_____

Hepatitis B Vaccine Acceptance/Refusal Consent

Hepatitis B is a viral infection caused by the hepatitis B virus (HBV) which causes death in 1% to 2% of people affected. Most people with Hepatitis B recover completely, but approximately 5% to 10% become transmitters of the virus, although they do not show symptoms of the virus. Some infected people may develop chronic active hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Immunization against Hepatitis B can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer. Spores of HBV can survive as long as one week in hand-pieces, equipment, charts or uniforms, so all healthcare workers and their families can be exposed.

Any FDA-approved hepatitis vaccine is acceptable. Currently, Engerix-B is available. Full immunization usually occurs after two doses of vaccine and a booster, given over a six-month period, although some persons may not develop immunity even after three doses. There is no evidence that the vaccine has ever caused Hepatitis B. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of immunization. The duration of the immunity is unknown at this time. There is no guarantee that you will become immune or that you will not experience any adverse side effects from the vaccine.

The incidence of side effects: Some people experienced tenderness and redness at the site of the injection. Low grade fever may occur. Rash, nausea, joint pain and mild fatigue have been reported.

The vaccine is not recommended if pregnant, unless approved by your physician.

This practice is offering the series of three injections of the Hepatitis B Vaccine on a voluntary basis to Exposure Category 1 and 2 employees.

ACCEPT Vaccination ... Yes, I choose to receive the Hepatitis B Vaccine, Energix-B.

Employee's Name:_____ Start Date: _____

Employee Signature: _____ Date:_____

ALREADY Vaccinated ... I already have received the Hepatitis B Vaccine. I am aware that I am eligible to receive booster doses, if needed.

Employee's Name:_____ Booster Desired? Yes No

Employee Signature: _____ Date:_____

REFUSE Vaccination: I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B Vaccine, I can receive the vaccination series at no charge.

Employee's Name:_____ Start Date: _____

Reason for Refusal: _____

Employee Signature: _____ Date: _____

OSHA Hazard Communication/Waste Training

Practice Name: _____ Date:_____

Employee's Name: _____ Position: _____

On the date indicated above, an information and training session was given for the Exposure Category 1, 2 or 3 employee indicated above, at the dental practice of the employer indicated above, on the subject of OSHA training in our Hazard Communication Plan and Hazardous Waste Management Plan.

The Training session was conducted by: ☐E.S.C. Other _____

Type of Training: ☐Orientation ☐Scheduled Review ☐New Information ☐Remedial Review

Name of Trainer: _____

Signature of Trainer_____ Date: _____

My OSHA Training in the Hazard Communication Plan has been completed. As a result of this training I fully understand:

☐ What this practice's Hazard Communication Plan is, and why we need it.....☐Yes ☐No

☐ The "Right-To-Know" Law for my protection while working in this practice.....☐Yes ☐No

☐ How to understand and use Material Safety Data Sheets .....☐Yes ☐No

☐ How to label hazardous materials and what the labels mean.....☐Yes ☐No

☐ This practice's Emergency Procedures for spills .....☐Yes ☐No

☐ This practice's Emergency Procedures for exposures.....☐Yes ☐No

☐ This practice's Fire Drill and the how to use the fire extinguishers .....☐Yes ☐No

☐ How to administer First Aid, using our First Aid Kit and First Aid Manual .....☐Yes ☐No

☐ How to assure safety from Radiation Exposure.....☐Yes ☐No

Employee Signature: _____ Date:_____

My OSHA Training in the Hazardous Waste Management Plan has been completed. As a result of this training I fully understand:

☐ How to handle and dispose of hazardous chemicals.....☐Yes ☐No

☐ How to handle and dispose of contaminated sharps .....☐Yes ☐No

☐ How to handle and dispose of other contaminated waste (if applicable) .....☐Yes ☐No

Employee Signature: _____ Date:_____

OSHA Bloodborne Pathogens Standards Training

Practice Name: _____ Date:_____

Employee's Name: _____ Position: _____

On the date indicated above, an information and training session was given for the Exposure Category 1 or 2 employee indicated above, at the dental practice of the employer indicated above, on the subject of preventing occupational exposure to bloodborne diseases.

The Training session was conducted by: ☐E.S.C. Other _____

Type of Training: ☐Orientation ☐Scheduled Review ☐New Information ☐Remedial Review

Name of Trainer: _____

Signature of Trainer_____ Date: _____

My OSHA Training in the Bloodborne Pathogens Standard has been completed. As a result of this training I fully understand:

☐ The modes of transmission of bloodborne disease.....☐Yes ☐No

☐ How to recognize tasks with a disease transmission hazard .....☐Yes ☐No

☐ How to apply the concept of Universal Precautions.....☐Yes ☐No

☐ How to handle non-routine hazardous tasks.....☐Yes ☐No

☐ The requirements for Hepatitis B Immunization .....☐Yes ☐No

☐ How to comply with standard operating procedures for sterilization .....☐Yes ☐No

☐ The location, use and limitations of protective equipment.....☐Yes ☐No

☐ How to handle accidental exposure to blood and saliva .....☐Yes ☐No

☐ The safe handling and disposal of contaminated waste.....☐Yes ☐No

☐ The safe handling and disposal of sharp items.....☐Yes ☐No

☐ The risks from HBV/HIV and other pathogens to pregnant workers.....☐Yes ☐No

☐ The necessary disinfection/sterilization techniques for our practice.....☐Yes ☐No

☐ The to handle blood spills .....☐Yes ☐No

☐ The proper technique for handwashing.....☐Yes ☐No

☐ Other:_____.....☐Yes ☐No

Employee Signature: _____ Date:_____

3-Month Employee Self-Evaluation

Employee's Name: _____ Evaluation Date: _____

Please answer the following questions, to give us your opinion on how well your training is progressing.

☐ Do you feel that the job you are now performing was described accurately to you and is it what you expected? ☐Yes, if ☐No, how does it differ from what you had anticipated?

_____

_____

☐ What methods of training have been provided for you and was this training clear and understandable? Comment if no:

Demonstrations? ☐Yes ☐No Comment _____

Training Manuals? ☐Yes ☐No Comment _____

Other Literature? ☐Yes ☐No Comment _____

On the Job Training? ☐Yes ☐No Comment _____

☐ Category 1 & 2 only: Do you understand clearly our Exposure Control Plan? Do you need review in this plan? ☐Yes ☐No Comment:

_____

☐ Category 1 & 2 only: Have you received proper vaccines and/or booster/titre check? (Form/waiver signed?) ☐Yes ☐No Comment:

_____

☐ Do you understand clearly our Hazard Communication Plan? Do you need review in this plan? ☐Yes ☐No Comment:

_____

☐ What areas of training do you still need in order to feel comfortable in your current job design? ☐Yes ☐No Comment:

_____

☐ Is there a "platform" regarding open communication with the doctor and staff members, and do you feel the communication lines are open? ☐Yes ☐No Comment:

_____

☐ Is sufficient time set aside for proper follow-up and communication with the doctor and staff members, if needed? ☐Yes ☐No Comment:

_____

☐ Through your own observation, what suggestions do you have for improvements or creative ideas within your job design/department? ☐Yes ☐No Comment:

☐ Other Comments: _____

Follow-up Required: _____

_____

Periodic Evaluation of Employee OSHA Training

Employee's Name: _____ Evaluation Date: _____

Evaluator's Signature: _____

Make copies of this page and complete the following evaluation every twelve months for Category 1 or 2 employees.

Check off the YES or NO response. If a NO response, schedule and train the employee in that area within 15 days of this evaluation.

- ☐ Is the staff member following universal precautions? ..... ☐Yes ☐No
- ☐ Can this employee distinguish tasks that carry a risk of disease transmission? ..... ☐Yes ☐No
- ☐ Has this staff member been immunized for Hepatitis B Virus? ..... ☐Yes ☐No
- ☐ Is this staff member complying with the standard operating procedures specified in this practice's Written Exposure Control Plan? ..... ☐Yes ☐No
- ☐ Does this staff member have unrestricted access to personal protective equipment? ..... ☐Yes ☐No
- ☐ Is this staff member safely and correctly handling infectious and hazardous waste daily? ..... ☐Yes ☐No
- ☐ Is this staff member safely handling and disposing of "sharp" items? ..... ☐Yes ☐No
- ☐ Is this staff member properly identifying and handling contaminated waste ..... ☐Yes ☐No
- ☐ Is this staff member following standard operating procedures (SOP) for handwashing ..... ☐Yes ☐No
- ☐ Is this staff member following SOP for sterilization/disinfection? ..... ☐Yes ☐No
- ☐ Is this staff member following SOP for decontaminating environmental surfaces ..... ☐Yes ☐No
- ☐ Is this staff member following SOP for housekeeping? ..... ☐Yes ☐No
- ☐ Has this staff member had an accidental exposure to blood since the last evaluation? ..... ☐Yes ☐No
- ☐ Is this staff member adequately protected from exposure to bloodborne diseases? ..... ☐Yes ☐No
- ☐ COMMENTS: _____

Training is SCHEDULED for the above NO answers for (date): _____

Training was COMPLETED for the above NO answers on (date): _____

Non-training situations above were resolved on (date): _____

Trainer's Signature: _____ Date: _____

Employee Bodily Fluid Exposure/Accident Report

Practice Name: _____ City:_____
Employee's Name: _____ Date of Inquiry: _____
Employee's Work Positions: _____ Date Reported: _____
Employee's Address: _____
Employee's Social Security #: _____-_____-_____ Work Phone:_____
Date of Birth:___/_____/____ Sex: ☐M ☐F
Was Employee Exposed While Working in Usual Position ? ☐Yes ☐No
Location Where Exposure/Accident Occurred: _____
How long in this position when injured? _____
How long employed in this practice when injured? _____ ☐Full Time ☐Part Time
Name of Witnesses: _____ Time of Day:_____ ☐AM ☐PM
Supervisor (or Environ. Safety Coord.): _____
All information relative to this incident will be confidential, only available to those having written consent of the exposed employee.

Employee Signature: _____ Date:_____

Cause of Accident/Exposure

☐Improper Procedure ☐Inattention ☐Haste ☐Attire ☐'Sharps' ☐Other: _____
Explain: _____
Due to Malfunction of Object/Substance? ☐No, If ☐Yes, Explain: _____
_____
Due to Unsafe Act? ☐No, If ☐Yes, Explain: _____
_____
Due to Unsafe Conditions? ☐No, If ☐Yes, Explain: _____
_____
Was Safety Equipment Required? ☐No, If ☐Yes, Describe Safety Equipment Required: _____
_____
Was Safety Equipment Used? ☐No, If ☐Yes, Describe Safety Equipment Used: _____
_____

Describe Exposure/Injury (include body parts affected: _____

_____
_____

Attending Physician's Evaluation

Physician's Diagnosis & Recommendations:
_____
_____

Physician's Signature: _____ Date:_____

Record of Employee Incident

Date of Incident: _____

Type of Incident: ☐Injury ☐Exposure ☐Illness ☐Other _____

Staff Member(s) Involved:	Soc. Security Number:	Occupation/Work Position(s):
_____	___-___-___	_____
_____	___-___-___	_____
_____	___-___-___	_____
_____	___-___-___	_____

Description of the Incident:

_____

_____

Location where Incident occurred: _____

Was medical treatment required? ☐No ☐Yes _____

Was there a loss of consciousness? ☐No ☐Yes _____

Was there a loss of work time? ☐No ☐Yes _____

Was there restriction of work/motion? ☐No ☐Yes _____

Was staff member transferred to other duties? ☐No ☐Yes _____

Evaluation of the Incident:

_____

_____

_____

Corrective Measures Taken (if required):

_____

_____

_____

Employee Signature: _____ **Date:**_____

Follow-up Notes and Comments:

_____

_____

_____

_____

Disciplinary Warning and Action Log

Employee's Name: _____ Position:_____

Problem #___ With Employee (include dates and description):

_____

_____

_____

Date Disciplinary Warning given: _____ Date Disciplinary Action taken: _____

The Warning Given or Action Taken:

_____

_____

_____

Signature of Doctor: _____ Date of INITIAL Entry: _____

Repeated Incidents of this problem. Note date of incident, whether warned (W) or disciplined (D).

(DATE)_____ ☐W ☐D (DATE)_____ ☐W ☐D (DATE)_____ ☐W ☐D

(DATE)_____ ☐W ☐D (DATE)_____ ☐W ☐D (DATE)_____ ☐W ☐D

Problem #___ With Employee (include dates and description):

_____

_____

_____

Date Disciplinary Warning given: _____ Date Disciplinary Action taken: _____

The Warning Given or Action Taken:

_____

_____

_____

Signature of Doctor: _____ Date of INITIAL Entry: _____

Repeated Incidents of this problem. Note date of incident, whether warned (W) or disciplined (D).

(DATE)_____ ☐W ☐D (DATE)_____ ☐W ☐D (DATE)_____ ☐W ☐D

(DATE)_____ ☐W ☐D (DATE)_____ ☐W ☐D (DATE)_____ ☐W ☐D

Make extra copies of this page if needed.

Notice of Voluntary Termination of Employment

Practice Name: _____

Employee's Name: _____

Date: _____ Position: _____

I, the employee noted above, hereby submit my voluntary resignation from the above-named employer for the following reasons:

_____

_____

_____

_____

My last day of employment with this practice will be on (date): _____

Employee's Signature: _____ Date:_____

Supervisor's Checklist for Last Day of Employment:

- ☐ Exit Interview Questionnaire Completed
- ☐ Office Key(s) Returned
- ☐ Pension & Profit Share Form filed for Termination
- ☐ Books/Tapes/Office Property Returned
- ☐ Final Check Received by employee within 3 days of last day of employment
- ☐ Disbursement amount on final check is correct
- ☐ Other _____

Forwarding Address (for further communications):

_____

_____

_____

_____

I have completed the above checklist and find that everything is in order.

Employee's Signature: _____ Date:_____

Doctor/Supervisor's Signature: _____ Date:_____

Employee Exit Interview Questionnaire

Practice Name: _____ Date:_____

Employee's Name: _____ Position:_____

Date Hired: _____ Date of Last Day of Employment: _____

In order for us to improve your position for your replacement, please answer the following questions:

☐ When you were hired, did you understand which positions you were hired for and the kind of work they entailed?

☐Yes ☐No Comment: _____

☐ Was this a new position that you had to create when you were hired, or did it already exist?

☐New ☐Already Existed Comment: _____

☐ Have you trained your replacement in all aspects of this position?

☐Yes ☐No Comment: _____

☐ If not, what else does your replacement need to be trained in?

☐Nothing, Comment: _____

☐ If you could change any part of the practice, what would it be?

☐Nothing, Comment: _____

☐ If you could change any part of your position, what would it be?

☐Nothing, Comment: _____

☐ Do you feel that we represent our goals and visions as a team?

☐Yes ☐No Comment: _____

☐ Are you aware of any incidents in this practice that have not been reported?

☐Yes ☐No Comment: _____

☐ Other Comments: _____

_____

Employee's Signature: _____ Date:_____

Supervisor's Signature: _____ Date:_____