

Shift Evaluation Form

*** CANDIDATE IS TO COMPLETE ONE EVALUATION PER SHIFT ***		
Candidate Name:		Provider Level:
Date:	Time In:	Time Out:
Primary Providers:		

Incident Log for Shift				
Call Log	Priority 1	Priority 2	Priority 3	Priority 4
Responses				
Transports				
Select any of the following incidents that you may have encountered on your shift: <input type="checkbox"/> Cardiac Arrest <input type="checkbox"/> Aviation Used <input type="checkbox"/> Auto Extrication <input type="checkbox"/> Technical Rescue <input type="checkbox"/> Other Critical/Unique Call			Number of Refusals/Patient Assists during your shift:	
List any additional shift activities, such as training topics or duties performed, here:				

Evaluator Signature:	Date:
Candidate Signature:	Date: