RNnetwork

TRAVELER REFERENCE

First Name _____ Last Name _____ (CST/CSP) _____

RNnetwork, in its consideration of a candidate depends on information from persons and institutions regarding the candidate's employment, training, and affiliations. Please complete this form to the best of your ability so the information you provide can be given consideration in the processing of this candidate's application in a timely manner. Thank you for your assistance.

Professional Reference

Previous Employer:		Unit Type:	
Address:		Size of Unit:	☐ 0-5 ☐ 6-15 ☐ 16-25 ☐ 25+
City:		Position Held:	
State:		Shift:	
Evaluator Name:		Start Date:	
Evaluator Title:		End Date:	
	(**Clinical Supervisor Preferred**)	Reason for Leaving:	

Performance Evaluation

Eligible for Rehire: Yes ☐ No ☐

	Exceeds Standards	Meets Standards	Does Not Meet Standards
Demonstrates proficiency with equipment?	☐	☐	☐
Completes job duties in a timely manner?	☐	☐	☐
Promotes continuity of care?	☐	☐	☐
Works as a team member?	☐	☐	☐
Punctuality and Attendance?	☐	☐	☐

Comments

This form will need to be verified, please list your telephone and/ or email below.

Evaluator Signature: _____ Date: _____

Phone/Email: _____

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