CARROLL HOSPITAL CENTER
90-DAY TRANSFER/PROMOTION REVIEW

Associate's Name: ___________________________ Associate No.: ___________ Dept.: _____________

Job Title: _____________________________ Transfer/Promotion Date: ________________

Section I: Transfer/Promotion Evaluation of Performance Due Date: _____________

Evaluation of Performance:

_____ Has met the standards of the position as outlined in the Job Description.

_____ Has completed all assigned competencies and mandatory hospital/department requirements for the current position.

_____ Exemplifies all SPIRIT values in carrying out job responsibilities and working with them.

Associate has successfully completed the Transfer/Promotion Review Period on _________________.
(Date)

**Transfer/Promotion Review has been extended until _____________.

**HR Authorization: ____

**Complete and attach Performance Improvement Action Plan

If applicable, please attach Age Related Competency Assessment.

Section II: Associate's Goals

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Section III: Additional Feedback (Optional)

Leader Comments:

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Associate Comments:

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Associate's Signature: ____ **Date:** ________________

Leader's Signature: ____ **Date:** ________________

PLEASE RETURN COMPLETED FORM TO HR