

Application for Clinical Excellence Program

Name: _____
First Middle Last

Address: _____

City State Zip

Phone: _____
Home Other Contact

Position: _____

Department # _____ Hospital: _____

Unit: _____ Average hours worked per pay period: _____

Unit Director: _____ Contact #: _____

Years of Practice: _____ Date of Hire: _____

Current Level: _____

Applying for Level: III IV

I am in compliance with attendance and punctuality policy: yes no

I demonstrate Methodist Excellence Standards: yes no

I am not on a corrective action plan: true false

I comply with unit staff meeting attendance expectation: yes no

Review of Portfolio by Liaison (Initial Program Application **Only**)

Liaison's Signature: _____ Date: _____

Applicant acknowledges that he/she will commit to meet the application criteria. Applicant understands that his/her level will be reviewed each year. Each year applicant will submit a portfolio to director at time of annual evaluation. Portfolio will document continued compliance with program criteria.

Employee Signature: _____ Date: _____

Leader's Signature: _____ Date: _____