COMMITTEE FOR PHYSICIAN HEALTH

MEDICAL SOCIETY OF THE STATE OF NEW YORK
99 WASHINGTON AVENUE, SUITE 410
ALBANY, NEW YORK 12210
(518) 436-4723 – 800-338-1833 – Fax: (518) 436-7943
Downloadable form at www.cphny.org (select "Forms)

QUARTERLY WORK-SITE MONITOR REPORT

(Please Print Clearly)

Date: _____

Work-site Monitor Name: _____ CPH Participant Name or Number: _____

Practice Site: _____ CPH Assistant Director: _____

REPORTING PERIOD: (Please CHECK)

____1st Quarter (January – March) – **Due March 31** ____3rd Quarter (July – September) – **Due September 30**

____2nd Quarter (April – June) – **Due June 30** ____4th Quarter (October – December) – **Due December 31**

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	(1) Consistently Poor Quality - (5) Consistently High Quality				
Record keeping	1	2	3	4	5
Available for practice and on-call schedule	1	2	3	4	5
Professional conduct/behavior with patients	1	2	3	4	5
Professional conduct/behavior with colleagues/staff	1	2	3	4	5

Would you like CPH to call you about this individual? ____ Yes ____ No

Any comments about this individual (compliments, investigations, complaints, etc)?

_____

_____

_____

_____

_____

_____ _____ _____

Monitor Signature **Date** **E-Mail Address**