APPENDIX "A"

WORKLOAD REVIEW FORM

Employees to complete every section

Date/Time of Occurrence: _____

Date Form Submitted to Hospital: _____

Site/Location _____ Department/Unit _____

Type of Work Being Performed _____

Number of Staff on Duty _____ Usual Number of Staff on Duty _____

I/We the undersigned, believe that I was/we were given an assignment that was excessive or inconsistent with quality patient care and/or created an unsafe working environment for the following reasons. (Provide brief description of problem/assignment below):

_____

_____

_____

_____

To correct this problem, I/we recommended:

_____

_____

_____

Name/Title of Immediate Supervisor Notified: _____

Date/Time of Notification _____

Response: _____

_____

Signature of Employee(s) & Printed Name(s) on Line below:

Printed Name	*Signature*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I/we do not agree with the resolution of my concern