Evaluation of Student Assistance Program (SAP) Counselor

To be Filled out by **School** Personnel

Period of Review
From: Month _____Year_____ To: Month _____Year_____
SAP Counselor's Name: _____

School: _____ Number of days SAP Counselor is there _____

Your Name: (please print) _____Title: _____

1. Rate the following qualities (circle the appropriate number)

	Needs Improvement				Excellent
Accessibility	1	2	3	4	5
Accountability	1	2	3	4	5
Appropriate attire	1	2	3	4	5
Collaborates well	1	2	3	4	5
Cooperation	1	2	3	4	5
Dependability	1	2	3	4	5
Initiative	1	2	3	4	5
Leadership	1	2	3	4	5
Presentation skills	1	2	3	4	5
Professionalism	1	2	3	4	5
Promptness	1	2	3	4	5
Works well with staff	1	2	3	4	5
Works well with students	1	2	3	4	5

2. Counselor**'s** strengths:

3. Counselor's areas of needed growth:

4. Would you recommend continued employment? (If no**,** please tell us why**.**)

5. Overall rating: Excellent Good Average Fair Poor

   Why?

6. What has been the most helpful aspect in having a Student Assistance Program Counselor in your school?

7. What changes would you make to your Student Assistance Program next year?

8. What are your program goals for next year?