



Texas Workforce Commission
Purchasing from People with Disabilities Program
Employee-Centered Professional Assessment



General Information

Employee's Name:	Employee ID:
Assessor's Name:	Date of Assessment:
CRP Name:	

Employee Professional Skill Self-Assessment

Evaluate yourself on factors that apply to your employment duties. If a category does not apply to you, indicate N/A.

Rating Scale: 4 - Outstanding/Role Model 3 - Very Competent
2 - Satisfactory 1 - Inexperienced or Improvement Needed

Category	Self-Rating				
Technical Skills related to your specific job	N/A	1	2	3	4
Technical Knowledge (up-to-date on industry/discipline news, articles, and best practices)	N/A	1	2	3	4
Quality of Work Product (comprehensive, accurate, timely, etc.)	N/A	1	2	3	4
Utilization or Productivity	N/A	1	2	3	4
Business Development	N/A	1	2	3	4
Project Management Skills	N/A	1	2	3	4
Technology Skills	N/A	1	2	3	4
Time Management & Organizational Skills	N/A	1	2	3	4
Interpersonal Skills (positive attitude; ability to get along well with co-workers/clients/vendors)	N/A	1	2	3	4

Employee Professional Skill Self-Assessment (con't)

Category	Self-Rating				
Communication Skills - Verbal/Written (proposal/reports, letters, emails, etc.)	N/A	1	2	3	4
Innovation or Creativity	N/A	1	2	3	4
Collaboration/Teamwork	N/A	1	2	3	4
Mentoring Skills	N/A	1	2	3	4
Employee Policies (knowledgeable of and compliant with company policies and procedures)	N/A	1	2	3	4
Leadership Skills (applies to anyone--not restricted to supervisory level employees)	N/A	1	2	3	4
Professionalism (punctuality, attendance, conduct, responsiveness, and follow-through)	N/A	1	2	3	4
Overall	N/A	1	2	3	4

Employee Assessment of Work History

- Do you have any specialized training, certifications, or degrees related to a particular field?

- Are you seeking employment related to this field?

- What kinds of additional professional development or training would you like or need related to the desired field?

- Please describe any past work experience in this field:

Employment Preferences & Requirements

- Do you have a preferred work schedule?

- What is your preferred work location? Do you have the ability to commute, and if so, what is your preferred commute time?

- What are your compensation requirements?

- Do you have any accommodation needs?

- Do you have any other preferences or requirements that should be taken into consideration as a part of this plan?

Goals and Objectives

Develop professional development goals for the upcoming year and detail what assistance can be provided by your employer:

Goal 1:

Objectives	Date Set	Projected Achievement Date	Date Achieved
A:			
B:			
C:			

Support provided by employer:

Description of abilities at entrance of training:

Goal 2:

Objectives	Date Set	Projected Achievement Date	Date Achieved
A:			
B:			
C:			

Support provided by employer:

Description of abilities at entrance of training:

Goal 3:

Objectives	Date Set	Projected Achievement Date	Date Achieved
A:			
B:			
C:			

Support provided by employer:

Description of abilities at entrance of training:

Goals and Objectives (con't)

Goal 4:

Objectives	Date Set	Projected Achievement Date	Date Achieved
A:			
B:			
C:			

Support provided by employer:

Description of abilities at entrance of training:

Goal 5:

Objectives	Date Set	Projected Achievement Date	Date Achieved
A:			
B:			
C:			

Support provided by employer:

Description of abilities at entrance of training:

Additional Comments

Additional comments, if any: _____

Signatures

Employee's Signature

I understand that this employment plan can include goals and training outside of the CRP environment. I have been informed of my employment options in competitive integrated employment and understand that my employers will assist me in obtaining my employment goals, whatever they might be.

By signing below, I the employee or authorized representative, agree with the Professional Assessment's goals and objectives recorded above. *If you do not agree, do not sign this form.*

Employee's Signature:

Date:

Legally authorized representative's signature, if any:

Date:

Assessor's Signature

By signing below, I the Assessor, certify that I:

- Identified the goals, objectives and training for the employee's plan with the employee, legal authorized representative (if any), and VR counselor as appropriate;
- Discussed the Professional Assessment with the employee and the employee's legal authorized representative, if any;
- All signatures were obtained on the date stated in the date field of the form;

Assessor's Signature:

Date:

Assessor's Printed Name and Title:

TWC Vocational Counselor's Signature (if applicable)

By signing below, I the VR Counselor, agree with the goals and objectives in the above Professional Assessment.

VR Counselor's Signature:

Date:

VR Counselor's Printed Name: