

REPORT OF SUPERVISED PRACTICE

Licensee _____ **RN** _____ **LPN** _____
 Month(s) Reporting _____ Shift _____ Hours per week _____
 Participant's position _____ Unit assigned to _____

Please evaluate the professional performance of the above named nurse. The purpose of this evaluation is to provide monitoring information to the Peer Assistance Committee. It is understood by all parties that this information will remain **confidential** and will only be released by written authorization of the above named nurse.

Please circle the appropriate number. Excellent <5-4-3-2-1>Poor. Explain any ratings below 3. Additional comments may be made in the space provided on the back of this form.

WORK HABITS	RATING	COMMENTS
Completes assignments	5 - 4 - 3 - 2 - 1	
Attendance/Punctuality	5 - 4 - 3 - 2 - 1	
Follows policy and procedures	5 - 4 - 3 - 2 - 1	
Organizes/Plans work effectively	5 - 4 - 3 - 2 - 1	
THOUGHT PROCESS	RATING	COMMENTS
Functions independently	5 - 4 - 3 - 2 - 1	
Handles complex tasks	5 - 4 - 3 - 2 - 1	
Utilizes problem solving ability	5 - 4 - 3 - 2 - 1	
Manages stressful situations	5 - 4 - 3 - 2 - 1	
INTERPERSONAL RELATIONS	RATING	COMMENTS
Works as a team member	5 - 4 - 3 - 2 - 1	
Communicates effectively	5 - 4 - 3 - 2 - 1	
Does the nurse have access to or administer controlled substances, including Stadol or Nubain?	Yes No	
Have there been any problems with documentation of medications?	Yes No	
Has any job related behavior warranted requesting a drug/alcohol screen? (If yes, please explain on the back of this form.)	Yes No	
Have there been any incidents requiring counseling, conference, oral/written warnings since last report? (If yes, explain and attach copy of documents.)	Yes No	

(Name of Nurse _____)

SUPERVISION

How frequently is the Nurse supervised? _____

How is supervision provided? _____

Additional Comments: _____

_____ Please call the Peer Assistance Office at (405)525-2277 to discuss any concerns or to receive any clarification regarding the nurse's individual contract. Thank you.

Supervisor's Signature _____ Date: _____

Supervisor's name and title (type or print) _____

Supervisor's telephone number _____

Employing Institution _____

Individual with primary responsibility for monitoring participant, **if different** from supervisor:
Signature _____ Title _____
Telephone Number _____ Date _____

**Please mail completed form directly to: Peer Assistance Program
2915 N. Classen Blvd., Suite 215
Oklahoma City, OK 73106**