

Missouri State Board of Nursing
 PO Box 656
 Jefferson City, MO 65109
 Fax 573-522-2143
 Email: janet.wolken@pr.mo.gov

Quarterly Employment Update

Nurse: Please complete the top portion of the form. Submit this form to indicate your current employment status. If you are unemployed, complete the unemployed evaluation portion of the form. Instructions to employer: Please complete this form to assist the Board of Nursing in monitoring this nurse. This nurse is required to provide you with a copy of the disciplinary documents, which is either an Order or a Settlement Agreement. One of the conditions of this discipline is that the nurse must ensure that a performance evaluation is submitted by the supervisor. The nurse will provide you with due dates.

To Be Completed by the Nurse Regardless of Employment Status	
Nurse's Name and License Number	Job Title
<input type="checkbox"/> I am currently not employed anywhere and have not been employed for the following dates: _____ If you check this box, sign, date and return the form.	<input type="checkbox"/> I am currently employed. If you check this box, your employer must complete the rest of this form and return it to the Board of Nursing by the deadline date provided to you. If you have more than one employer, a form is required from each employer.

This section must be completed whether the nurse is employed in a nursing position or non-nursing position and regardless if the nurse is employed by a healthcare institution.	
Dates of Employment:	Supervisor's Name & Title:
Supervisor's Telephone Number:	Institution Name & Address
Supervisor's Signature	Date Completed
Indicate Shifts: <input type="checkbox"/> Day <input type="checkbox"/> Evening <input type="checkbox"/> Night	
Attendance met expectations? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, describe attendance problems.	
Quality of Work: <input type="checkbox"/> Excellent <input type="checkbox"/> Satisfactory <input type="checkbox"/> Needs Improvement <input type="checkbox"/> Unsatisfactory	
Has an evaluation or counseling session been held with the nurse in the past 3 months? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, provide a copy if in written form or explain if evaluation or counseling was verbal.	
Have there been any incident reports, complaints, or concerns reported about this nurse? <input type="checkbox"/> No <input type="checkbox"/> Yes: If yes, provide copy if written or explain if verbal.	

If the nurse is employed in a nursing position, please continue. If the nurse is not employed in a nursing capacity, do not continue.
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Supervision Provided: <input type="checkbox"/> On-Site <input type="checkbox"/> None	
What medications has the nurse administered in the last 3 months? <input type="checkbox"/> Non-controlled drugs <input type="checkbox"/> Controlled drugs <input type="checkbox"/> None	
In the past quarter, did the nurse consistently complete these activities according to policy and standards of nursing practice? Comments	
Provide patient/resident/client care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Complete nursing documentation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Obtain/carry out provider orders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Administer medications	<input type="checkbox"/> Yes <input type="checkbox"/> No
Communicate with patient/residents/clients	<input type="checkbox"/> Yes <input type="checkbox"/> No
Communicate with colleagues/staff	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please attach a separate sheet explaining any no answers.	

Return Completed Form to:

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