

# MISSOURI STATE BOARD OF NURSING NON-NURSING EMPLOYMENT EVALUATION FORM

The nurse requesting that you complete this form is currently being disciplined by Order of the Missouri State Board of Nursing. The nurse is required to provide you with a copy of this Order. One of the conditions of this discipline is that the nurse must ensure that an employment evaluation is submitted by his or her supervisor to the Board. The nurse will provide you with due dates.

Nurse Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Date of Employment: \_\_\_\_\_ Date Terminated/Resigned \_\_\_\_\_

Name and Position of Immediate Supervisor: \_\_\_\_\_

**1. NURSE'S JOB TITLE:** \_\_\_\_\_

**2. DUTIES:**

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Sales       | <input type="checkbox"/> Manager                   |
| <input type="checkbox"/> Health Care | <input type="checkbox"/> Record Keeping/Accounting |
| <input type="checkbox"/> Services    | <input type="checkbox"/> Physical Labor            |
| <input type="checkbox"/> Clerical    | <input type="checkbox"/> Other: _____              |

**3. QUALITY OF WORK**

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Outstanding  | <input type="checkbox"/> Needs Improvement |
| <input type="checkbox"/> Satisfactory | <input type="checkbox"/> Unsatisfactory    |

**4. TO THE BEST OF YOUR KNOWLEDGE, DO YOU BELIEVE THE NURSE IS MAINTAINING ABSTINENCE FROM ALL MOOD-ALTERING CHEMICALS, INCLUDING ALCOHOL?**

- Yes       No       Unsure

**5. WERE YOU INFORMED OF THE BOARD'S ORDER BY THE NURSE?**

- Yes       No

**6. WERE YOU PROVIDED WITH A COMPLETE COPY OF THE ORDER BY THE NURSE?**

- Yes       No

IF YOU HAVE ADDITIONAL OR OTHER COMMENTS, PLEASE FEEL FREE TO MAKE THEM ON AN ADDITIONAL SHEET OF PAPER.

We appreciate your cooperation.

\_\_\_\_\_  
Signature and Title of Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agency/Institution

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Mailing Address of Agency/Institution

SEND REPORT TO:  
Mail: Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102  
Fax: 573-522-2143