

**MISSOURI STATE BOARD OF NURSING
NURSING PERFORMANCE EVALUATION FORM**

The nurse requesting that you complete this form has been placed on discipline by Order of the Missouri State Board of Nursing. This nurse is required to provide you with a copy of the Order. One of the conditions of this discipline is that the nurse must ensure that a nursing performance evaluation is submitted by his or her supervisor to the Board. The nurse will provide you with the due dates.

Nurse Name: _____ License Number: _____

Date of Employment: _____ Date Terminated/Resigned: _____

Name and Position of Immediate Supervisor: _____

1. NURSING PRACTICE AREA

- | | |
|--|--|
| <input type="checkbox"/> Medical/Surgical | <input type="checkbox"/> Emergency Room |
| <input type="checkbox"/> ICU | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Private Duty |
| <input type="checkbox"/> OB/Gyn | <input type="checkbox"/> Nurse Anesthetist |
| <input type="checkbox"/> OR/Recovery | <input type="checkbox"/> Other: _____ |

2. POSITION

- | | |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Supervisor | <input type="checkbox"/> Instructor |
| <input type="checkbox"/> Charge Nurse | <input type="checkbox"/> Private Duty |
| <input type="checkbox"/> Staff | <input type="checkbox"/> Other: _____ |

3. SHIFT/HOURS WORK

- | | |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Days | <input type="checkbox"/> Full time - |
| <input type="checkbox"/> Evenings | No. hours/wk _____ |
| <input type="checkbox"/> Nights | <input type="checkbox"/> Part time - |
| <input type="checkbox"/> PRN | No. hours/wk _____ |

4. Does the nurse have on site supervision by another nurse or physician for the entire shift/hours worked
 No Yes explain how nurse is being supervised

5. QUALITY OF WORK

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

Has an evaluation or counseling session been held with the nurse in the past 3 months?

- Yes No
 Written - Provide Copy
 Verbal - Explain:

Have there been any incident reports, complaints, concerns reported about this nurse?

- Yes No If yes, provide a copy and explain.

6. **DOES THE NURSE DEMONSTRATE ACCURACY AND ADEQUACY IN DOCUMENTATION?**
 Yes No If no, explain.
7. **TO THE BEST OF YOUR KNOWLEDGE, DO YOU BELIEVE THE NURSE IS MAINTAINING ABSTINENCE FROM ALL MOOD-ALTERING CHEMICALS, INCLUDING ALCOHOL?**
 Yes No Unsure
8. **DOES THE NURSE ADMINISTER CONTROLLED SUBSTANCES?**
 Yes No
9. **HOW OFTEN ARE MEDICATION RECORDS REVIEWED FOR ACCURACY?**
 Regularly Occasionally Never
10. **WERE YOU INFORMED OF THE BOARD'S ORDER BY THE NURSE?**
 Yes No
11. **WERE YOU PROVIDED WITH A COMPLETE COPY OF THE ORDER BY THE NURSE?**
 Yes No

PLEASE FEEL FREE TO MAKE ANY ADDITIONAL COMMENTS 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 REPORTS TO:
 Mail: Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102
 Fax: 573-522-2143

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