

REPORT OF SUPERVISED PRACTICE

Name of Peer Nurse: _____

Reporting Month(s) _____ 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? (This would include any medications of abuse such as Nubain, which is not a CDS.) | 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.

Supervising Nurse's Signature _____ Date: _____

Supervising Nurse's name and title (type or print) _____

Telephone number _____

Employing Institution _____

Nurse Manager's Signature _____ Date _____

Additional comments: _____

**Please mail completed form directly to: Peer Assistance Program
2901 N. Classen Blvd. Suite 101
Oklahoma City, OK 73106**