Oklahoma Board of Nursing **Telephone: 405-962-1800**
P.O. Box 52926 **Facsimile: 405-962-1819**
Oklahoma City, Oklahoma 73152 **Website: http://www.oklahoma.gov/nursing**

SELF-ASSESSMENT REPORT

Instructions:

- To be completed by the Licensee
- Complete entire form. Refer to Self Assessment Report Guidelines
- Submit quarterly; due by the 15th day of the following months: January, April, July and October, but no earlier than 30 days prior to the due date, whether or not you are employed in nursing.
- Responses to all areas are required. It is not acceptable to write "Nothing has changed" or "Not Applicable (N/A)" on the Report.

Reporting month(s) _____

Name _____ License Number _____
Address _____
Telephone Number _____

○ Has your address or telephone number changed since the last report? ( )Yes ( )No

Efforts to find employment (If not currently working in nursing) _____

Have you reviewed your Board Order/Agreement to Participate? ( )Yes ( )No
Do you continue to abide by its terms and conditions? ( )Yes ( )No. If no, please explain what problems you are having in following your Order. _____

Have you had any health related issues this reporting period? (ie.: medical procedures, medication changes, use of narcotics, etc.) ( )Yes ( ) No. If yes, please explain.

_____

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EMPLOYMENT

Name of Employer: _____
Address: _____
Telephone Number: _____
Job Title: _____ How long have you been with this employer:? _____
Hours worked per week: _____ Shift: _____
Job responsibilities (if employed in nursing) _____
_____
Did you work any overtime this reporting period? ( )Yes ( )No If yes, how many hours? _____ Please address any problems/concerns/accomplishments in the workplace:
_____
_____
_____

PROGRESS TOWARD COMPLETION

What are your plans to meet the terms of probation? _____
_____
_____
_____
Explain the progress toward your goals. _____
_____
_____
_____
Any questions or concerns you have? _____
_____
_____
_____
Any other information you wish to share? _____
_____
_____
_____

IF APPLICABLE ( )Yes ( )No

Identify your support systems _____
_____
_____
Address activities and experiences which you feel are contributing to your personal recovery.
_____
_____
_____

CERTIFY

I certify that the statements contained herein are true and completed to the best of my knowledge and belief.
Licensee Signature: _____ Date: _____