

REPORT OF SUPERVISED PRACTICE

Licensee: _____

Employing Institution: _____

Assigned to: _____ **Unit. Status:** Full time () Part time ()

Shift: _____ **Position:** _____

Has there been a change in position or responsibilities in the past three (3) months?

No () Yes () **Explain:** _____

Please evaluate the nursing practice of the above named Licensee who is on probation, pursuant to an Order by the Oklahoma Board of Nursing.

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 second page 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	

(Please circle the appropriate answers below).

If Licensee administers medications or has access to medications, have there been any problems with this?	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 below.)	Yes	No

(Go to Page 2)

SUPERVISION

How frequently is the Licensee supervised? Describe:

Describe how supervision is provided:

Have there been any incidents requiring counseling, conferences, oral/written warnings since last report? No () Yes () Explain and **PROVIDE A COPY OF THE DOCUMENTATION WITH THIS REPORT:**

Strengths and Weaknesses of Licensee:

Additional Comments:

Please call the Oklahoma Board of Nursing Office at (405) 962-1827 to discuss any concerns or to receive any clarification regarding the Licensee's probation. Thank You.

Unit Manager/Director Name: _____

Reporting Period: _____ to _____ 20 ____

Total number of hours worked by the Licensee during the above reporting period: _____ hours. **(Include time and attendance records.)**

Signature: _____ Title: _____

Telephone Number: _____ Date: _____