PEER ASSISTANCE PROGRAM
P.O. Box 52926
Oklahoma City, OK 73152

OKLAHOMA BOARD OF NURSING
405/525-2277
Fax 405/525-0350
http://www.oklahoma.gov/nursing

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**
P.O. Box 52926
Oklahoma City, OK 73152