

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 below: 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 indicate the appropriate answers below:

If Licensee administers medications or has access to medications, have there been any problems with this?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have there been any problems with documentation of medications?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has any job-related behavior warranted requesting a drug/alcohol screen? (If yes, please explain on the next page.)	Yes <input type="checkbox"/> No <input type="checkbox"/>

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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 the last report?

No ☐ Yes ☐ If yes, explain and **PROVIDE A COPY OF THE DOCUMENTATION WITH THIS REPORT:**

Strengths and Weaknesses of Licensee:

Additional Comments:

Please call the OK 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.**

Unit Manager/Director Signature: _____

Title: _____

Telephone Number: _____ Date: _____

Mailing Address:

P.O. Box 52926
Oklahoma City, OK 73152

Physical Address:

2501 N. Lincoln Blvd., Ste. 207
Oklahoma City, OK 73105

Phone number: (405) 962-1800 **Facsimile:** (405) 962-1819 **Website:** oklahoma.gov/nursing