

REGISTERED NURSE

EMPLOYER STATUS REPORT FOR THE MONTH OF _____, 20_____
COMPLIANCE DIVISION

NAME OF RESTRICTED INDIVIDUAL: _____

FACILITY: _____

TELEPHONE NUMBER: _____

ORIGINAL DATE OF EMPLOYMENT: _____

SIGNATURE/TITLE

OF PREPARER: _____ DATE OF REPORT: _____

1. **FIELD/TYPE** of Nursing: (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Medical/Surgical | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Home Health |
| <input type="checkbox"/> Critical Care | <input type="checkbox"/> Nursery | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Physician's Office |
| <input type="checkbox"/> OR/Recovery Room | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Rural Health Clinic |
| | <input type="checkbox"/> Hospital | <input type="checkbox"/> Other/describe: _____ |

2. **POSITION:**

- | | | |
|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Staff Nurse | <input type="checkbox"/> Instructor | <input type="checkbox"/> Nurse Anesthetist |
| <input type="checkbox"/> Charge Nurse | <input type="checkbox"/> Supervisor | <input type="checkbox"/> Nurse Practitioner |
| | | <input type="checkbox"/> Other/describe: _____ |

3. **SCHEDULE:** (Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Days 7-3 | <input type="checkbox"/> Part-time | <input type="checkbox"/> 12-Hour Shifts |
| <input type="checkbox"/> Days 8-5 | (If part-time include the number
of hours worked) | <input type="checkbox"/> Varied |
| <input type="checkbox"/> Evenings 3-11 | <input type="checkbox"/> Full-time | <input type="checkbox"/> Other/describe: _____ |
| <input type="checkbox"/> Nights 11-7 | | |

Overtime work pattern: Always at employer's request
 Request of licensee
 Never
 # Shifts O/T Worked: _____

4. **APPEARANCE:**

- Neatly, appropriately dressed
 Fair
 Unacceptable-Explain: _____

5. **ATTENDANCE:**

A. Number of absences: _____
 Excused
 Not Excused

Comments: (Include reason for absence) _____

B. Times Tardy: _____

Explanation: _____

6. **RELIABILITY:**

- Very Dependable
 Average
 Poor – Explain: _____

7. Briefly describe duties performed by restricted individual:

8. **JOB PERFORMANCE:**

- Above average
- Average
- Fair
- Unacceptable – Explain in detail on separate sheet
- Counseling received:
 - Verbal: _____ times regarding: _____ (Submit any counseling in detail on separate sheet)
 - Written: _____ times regarding: _____ (Submit any counseling in detail on separate sheet)

9. **MEDICATION ADMINISTRATION:**

A. Controlled substances

- Not applicable
- No errors or discrepancies
- Errors _____, Explain: _____
- Discrepancies _____, Explain: _____

B. Non-controlled medications

- Not applicable
- No errors or discrepancies
- Errors _____, Explain: _____
- Discrepancies _____, Explain: _____

NOTE: If discrepancies or errors are noted, relevant documents including , but not limited to, copies of physician’s orders, MAR’s, nurses notes and variance incident reports should be submitted with the monthly report form.

10. **DOCUMENTATION:**

- Above average
- Average
- Fair
- Unacceptable – Explain on separate sheet
- Counseling received:
 - Verbal: _____ times regarding: _____ (Submit any counseling in detail on separate sheet)
 - Written: _____ times regarding: _____ (Submit any counseling in detail on separate sheet)

Documentation/chart review audit sheet to be attached to monthly evaluation. (Should include the type(s) of documentation reviewed and the number of each reviewed.)

11. **ASSESSMENT SKILLS:**

(a)	Assessments were performed during the report period: (If no is checked, skip to item #12)	Yes _____	No _____
		<u>ABOVE AVERAGE</u>	<u>AVERAGE</u>
		<u>FAIR</u>	<u>UNACCEPTABLE/EXPLAIN</u>
(b)	Objective data collection (Includes physical assessment, etc.)	_____	_____
(c)	Subjective data collection (symptoms noted by patient, etc.)	_____	_____
(d)	Defines problems/identifies abnormal findings	_____	_____
(e)	Develops care plan	_____	_____
(f)	Evaluates response to care	_____	_____

12. **COMMENTS/OTHER:**

