EMPLOYER STATUS REPORT FOR THE MONTH OF _________________________, 20________

NAME OF RESTRICTED INDIVIDUAL: __________________________________________________________________

FACILITY: _____________________________________________________________________________________________

__________________________________________________________  TELEPHONE NUMBER: ______________________

ORIGINAL DATE OF EMPLOYMENT: ____________________________________________________________________

SIGNATURE/TITLE OF PREPARATOR: __________________________________________________  DATE OF REPORT:___________________

1. **FIELD/TYPE** of Nursing: (Check all that apply)
   - ( ) Medical/Surgical
   - ( ) Critical Care
   - ( ) Emergency Room
   - ( ) OR/Recovery Room
   - ( ) OB/GYN
   - ( ) Pediatrics
   - ( ) Chemical Dependency
   - ( ) Nursery
   - ( ) Hospital
   - ( ) Home Health
   - ( ) Nursing Home
   - ( ) Physician’s Office
   - ( ) Rural Health Clinic
   - ( ) Other/describe: ______________

2. **POSITION**: (Check all that apply)
   - ( ) Staff Nurse
   - ( ) Charge Nurse
   - ( ) Instructor
   - ( ) Supervisor
   - ( ) Nurse Anesthetist
   - ( ) Nurse Practitioner
   - ( ) Other/describe: ______________

3. **SCHEDULE**: (Check all that apply)
   - ( ) Days 7-3
   - ( ) Days 8-5
   - ( ) Evenings 3-11
   - ( ) Nights 11-7
   - ( ) Part-time
   - ( ) 12-Hour Shifts
   - ( ) Varied
   - ( ) Other/describe: ______________
   - Overtime work pattern:
     - ( ) Always at employer’s request
     - ( ) Request of licensee
     - ( ) Never
     # Shifts O/T Worked: ____________

4. **APPEARANCE**: (Check all that apply)
   - ( ) Neatly, appropriately dressed
   - ( ) Fair
   - ( ) Unacceptable-Explain: _______________________________________________________________________

5. **ATTENDANCE**: (Check all that apply)
   - A. Number of absences: ____________
     - ( ) Excused
     - ( ) Not Excused
   - Comments: (Include reason for absence) ____________________________________________________________
   - B. Times Tardy: ____________
   - Explanation: ___________________________________________________________________________________

6. **RELIABILITY**: (Check all that apply)
   - ( ) 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 _____

      ABOVE AVERAGE  
      AVERAGE  
      FAIR  
      UNACCEPTABLE/EXPLAIN

   (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:**

____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________