MISSISSIPPI BOARD OF NURSING
713 Pear Orchard Road
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Ridgeland, MS 39157
Fax: 601-957-6301

RECOVERING NURSE PROGRAM
EMPLOYER MONTHLY EVALUATION

For The Month Of:_____

Facility Name: _____ **Day shift** _____ **Night Shift**_____

Address: _____

Supervisor: _____ **Title:** _____

Supervisor Phone: _____ **Employee Unit Phone:** _____

Employee Name: _____ **License No:**_____

Number of Hours Scheduled to Work:_____ **Number of Hours Worked:**_____

1. APPEARANCE
- a. Neat, appropriately dressed [ ]
- b. Fair [ ]
- c. Poor [ ]
- d. Unacceptable [ ]

2. ATTENDANCE
- a. Number of absences _____
- b. Date(s) of absences_____
  _____
- c. Reason for absence _____
  _____

3. PUNCTUALITY
- a. Arrives on time
- b. Number of times tardy _____
  Reason for tardiness_____
  _____

4. RELIABILITY
- a. Very Dependable [ ]
- b. Average [ ]
- c. Poor [ ] explain _____
  _____

5. COMMUNICATION SKILLS
- a. Excellent [ ]
- b. Average [ ]
- c. Poor [ ]

6. TEAMWORK PRACTICE
- a. Excellent [ ]
- b. Average [ ]
- c. Poor [ ]

7. DOES EMPLOYEE SEEK SUPERVISION WHEN NEEDED?
- a. Yes [ ]
- b. Not Consistently [ ]
- c. No [ ]

8. CLINICAL PERFORMANCE
- a. Above Average [ ]
- b. Average [ ]
- c. Fair [ ]
- d. Unacceptable [ ] (Explain)

_____

COMMENTS ON PERFORMANCE: _____

_____

_____ _____
EMPLOYEE'S SIGNATURE **DATE**

_____ _____
SUPERVISOR'S SIGNATURE **DATE**