

# Mississippi Nurse Voluntary Program (MnVP)

## MnVP Employer Report

Participant's Name: \_\_\_\_\_

Report for (circle one):

Initial Jan-Mar Apr-Jun Jul-Sept Oct-Dec Year: 20\_\_\_\_\_

Employer: \_\_\_\_\_

Worksite Monitor: \_\_\_\_\_ Contact # \_\_\_\_\_

Status: Full-Time Part-Time # of hours/week: \_\_\_\_\_

Overtime: Yes No If yes, how many hours on average: \_\_\_\_\_

Position: \_\_\_\_\_ Shift: \_\_\_\_\_

Has there been a change in position or responsibilities in the past three (3) months? Yes No Explain: \_\_\_\_\_

Please evaluate the nursing practice on a scale of 1-5 with 1 being poor and 5 being excellent. Any rating below 3 should be explained:

- Work Habits
  - Completes Assignments: 1 2 3 4 5
    - Comments: \_\_\_\_\_
  - Attendance/Punctuality: 1 2 3 4 5
    - Comments: \_\_\_\_\_
  - Follows Policies and Procedures: 1 2 3 4 5
    - Comments: \_\_\_\_\_
  - Organizes/Plans Work Effectively: 1 2 3 4 5
    - Comments: \_\_\_\_\_
- Thought Process
  - Functions Independently: 1 2 3 4 5
    - Comments: \_\_\_\_\_
  - Handles Complex Tasks: 1 2 3 4 5
    - Comments: \_\_\_\_\_
  - Utilizes Problem Solving Ability: 1 2 3 4 5
    - Comments: \_\_\_\_\_
  - Manages Stressful Situations: 1 2 3 4 5
    - Comments: \_\_\_\_\_
- Interpersonal Skills
  - Works as a Team Member: 1 2 3 4 5
    - Comments: \_\_\_\_\_
  - Communicates Effectively: 1 2 3 4 5
    - Comments: \_\_\_\_\_

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If the nurse administers controlled substances or has access to controlled substances, have there been any problems?

Circle One: Yes No N/A

Have there been any problems with documentation of controlled substances? Circle One: Yes No N/A

Have there been any problems with documentation of any medications? Circle One: Yes No N/A

Has any job related behavior resulted in the request for a drug/alcohol screen? Circle One: Yes No N/A

Have there been any problems with patient care and/or documentation? Circle One: Yes No N/A

If yes to any of the above questions, please explain:

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Type of Supervision:

\_\_\_ Direct (The supervising nurse must be physically present in the patient care unit where that patient is receiving nursing care or participant is providing patient care in a healthcare-related occupation)

\_\_\_ Indirect (The supervising nurse isn't required to be on the same unit or ward as participant but should be on the facility grounds and readily available to provide assistance, if necessary)

Name of Supervisor and License Number (please list all):

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How Frequent is the participant supervised? \_\_\_\_\_

How is supervision provided? \_\_\_\_\_

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Have there been any incidents requiring counseling, conferences, oral/written warnings since last report? Yes No

If yes, please explain and attach a copy of the documentation to this report: \_\_\_\_\_

Strengths of Participant: \_\_\_\_\_

Areas for Improvement of Participant: \_\_\_\_\_

Additional Comments: \_\_\_\_\_

### ANY NEGATIVE FINDINGS MUST BE IMMEDIATELY REPORTED TO THE MISSISSIPPI NURSE VOLUNTARY PROGRAM

Please call MnVP at 601.957.6300 to discuss any concerns or to receive any clarification regarding the participant.

By my signature below, I certify that the above information is correct.

Worksite Monitor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Worksite Monitor's Printed Name: \_\_\_\_\_

Worksite Monitor's Contact #: \_\_\_\_\_

**PLEASE MAIL, EMAIL AND/OR FAX THE COMPLETED FORM DIRECTLY TO MnVP (please include "Attention MnVP" on fax or Mail):** 713 S. Pear Orchard Rd, Ste 300, Ridgeland, MS 39157

MNVP@msbn.ms.gov  
601.957.6301 (fax)

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