713 S. Pear Orchard Rd.
Plaza II, Suite 300
Ridgeland, MS 39157
T: (601) 957-6300
F: (601) 957-6301

MISSISSIPPI
Board of Nursing

EMPLOYER REPORT OF SUPERVISED PRACTICE

Licensee Name: _____ **Reporting Date**: _____

Employing Institution: _____

Date of Hire: _____ Assigned to: _____ **Unit.**

Status: Full time ( ) Part time ( ) – No. Hrs/Wk _____ Overtime: Yes ( ) No. Hrs/Wk_____ No ( )

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 nurse who has a probationary license pursuant to an Order by the Mississippi Board of Nursing.

Please circle the appropriate number. Excellent <5-4-3-2-1->Poor. Explain any ratings below 3. Additional comments may be made in the space provided on the back 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	

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Licensee Name:_____ License Number: _____

PLEASE CIRCLE APPROPRIATE ANSWER

If nurse administers controlled substances or has access to controlled substances, have there been any problems with this?	Yes No
Have there been any problems with documentation of controlled substances?	Yes No
Have there been any problems with documentation of medications?	Yes No
Has any job related behavior warranted requesting a drug/alcohol screen? (If yes, please explain below.)	Yes No
Have there been any problems with patient care and/or documentation?	Yes No

TYPE OF SUPERVISION: (Minimum of 2 years' experience in the same or similar practice setting to which the Respondent is currently working)		**CHECK**
INDIRECT SUPERVISION: The supervising nurse is not required to be on the same unit or ward as Respondent but should be on the facility grounds and readily available to provide assistance and intervention if necessary.		
DIRECT SUPERVISION: The supervising nurse must be physically present in the patient care unit where that patient is receiving nursing care or Respondent is providing patient care in a healthcare-related occupation.		
NAME OF SUPERVISOR AND LICENSE NUMBER:		
1.	**4.**	
2.	**5.**	
3.	**6.**	
NOT APPLICABLE:		

SUPERVISION
How frequently is the licensee supervised?
How is supervision provided?
Have there been any incidents requiring counseling, conferences, oral/written warnings since last report? No ( ) Yes ( ) Explain and **ATTACH A COPY OF THE DOCUMENTATION TO THIS REPORT:**
Strengths and Weaknesses of Licensee:

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Licensee Name:_____ **License Number:** _____

Any negative findings must be immediately reported to the Mississippi Board of Nursing Compliance Division.

COMMENTS:

_____
_____
_____
_____
_____

Please call the Mississippi Board of Nursing: Compliance Division at (601) 957-6300 to discuss any concerns or to receive any clarification regarding the nurse's probation. Thank You.

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

Supervisor's Signature: _____ Date: _____
Supervisor's name and title: (type or print) _____
Supervisor's telephone number: _____

Department Manager/ Director:

Signature: _____ Title: _____

Telephone Number: _____ Date: _____

Email: _____

Please mail, email, and/or fax completed form directly to: Mississippi Board of Nursing: Attn: Compliance Division: 713 S. Pear Orchard Rd., Ste. 300, Ridgeland, MS 39157.

The email address is reception@msbn.ms.gov and the fax number is (601) 957-6301.

Please **circle** the compliance officer's name: V. Rucker N. Duncan R. Hance

Created: 2/1/2016
Modified 12/15/2020