Quarterly Employer Report

Participant's Name: _____

Report for (circle one):

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: _____
- Though Process
  - Function Independently: 1 2 3 4 5
    - Comments: _____
  - Handles Complex Tasks: 1 2 3 4 5
    - Comments: _____
  - Utilizes Program 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: _____

Revised June 2020

Mississippi Nurse Voluntary Program (MnVP)

713 Pear Orchard Road
Plaza II, Suite 300
Ridgeland, MS 39157
(601)957.6298-Office
(601)957.6301-Fax

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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:

_____

_____

_____

_____

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):

_____

_____

_____

How Frequent is the participant supervised? _____

How is supervision provided?_____

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IHave 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 601.957.6298 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
601.957.6301
MNVP@msbn.ms.gov

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