

**ARIZONA STATE BOARD OF NURSING**  
**4747 NORTH 7TH STREET, SUITE 200**  
**PHOENIX, ARIZONA 85014-3655**  
**TELEPHONE (602) 771-7860      FAX (602) 771-7882**  
**ATTENTION: "MONITORING"**

**CNA PERFORMANCE EVALUATION REPORT**

\_\_\_\_\_ is required to have submitted on his/her behalf a performance evaluation report every \_\_\_\_\_ months. Please complete and return this form to the address shown above.

Original Date of Employment: \_\_\_\_\_

Time Period Covered by this Evaluation: From: \_\_\_\_\_ To: \_\_\_\_\_

1. **FIELD/TYPE** of Nursing (check appropriate box)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Medical/Surgical      | <input type="checkbox"/> OB/GYN              | <input type="checkbox"/> Home Health       |
| <input type="checkbox"/> Critical Care         | <input type="checkbox"/> Nursery             | <input type="checkbox"/> Nursing Home      |
| <input type="checkbox"/> Emergency Room        | <input type="checkbox"/> Pediatrics          | <input type="checkbox"/> Behavioral Health |
| <input type="checkbox"/> OR/Recovery Room      | <input type="checkbox"/> Chemical Dependency |  |
| <input type="checkbox"/> Other/describe: _____ |  |  |

2. **SCHEDULE**: (check all that may apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Days 7- 3       | <input type="checkbox"/> Part - time           | <input type="checkbox"/> 12 - Hour Shifts |
| <input type="checkbox"/> Evenings 3 - 11 | <input type="checkbox"/> Full - time           | <input type="checkbox"/> Varied           |
| <input type="checkbox"/> Nights 11 - 7   | <input type="checkbox"/> Other/describe: _____ |   |

3. **ATTENDANCE**:

Number of days absent in the past 3 months: \_\_\_\_\_

Number of days tardy in the past 3 months: \_\_\_\_\_

- A pattern of absenteeism/tardiness does not exist.
- A pattern of absenteeism/tardiness does exist. Describe: \_\_\_\_\_

4. **QUALITY OF WORK**:

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Exceptional  | <input type="checkbox"/> Above Average  |
| <input type="checkbox"/> Satisfactory | <input type="checkbox"/> Unsatisfactory |

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

5. Does the CNA follow **POLICIES & PROCEDURES** (please comment)

- |   |  |
|---|--|
| <input type="checkbox"/> Exceptional    | <input type="checkbox"/> Above Average     |
| <input type="checkbox"/> Satisfactory   | <input type="checkbox"/> Needs Improvement |
| <input type="checkbox"/> Comment: _____ |  |

**CONTINUED ON BACKSIDE \***

6. Does the CNA demonstrate accuracy and adequacy in **DOCUMENTATION**:

- Exceptional
- Satisfactory
- Comment: \_\_\_\_\_
- Above Average
- Needs Improvement

7. **INTERPERSONAL RELATIONSHIPS** with co-workers/peers:

- Very Good
- Needs Improvement
- Comment: \_\_\_\_\_
- Satisfactory

8. In the past 3 months, has the CNA been counseled or disciplined in the work setting:

- Yes
- No
- Comment: \_\_\_\_\_

9. Use this space for further comments, questions or concerns:

\_\_\_\_\_

**THANK YOU FOR YOUR COOPERATION**

\_\_\_\_\_  
Date of Report

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Supervisor Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Supervisor Title

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Telephone #