

ARIZONA STATE BOARD OF NURSING
4747 NORTH 7TH STREET, SUITE 200
PHOENIX, ARIZONA 85014-3655
TELEPHONE (602) 771-7800 FAX (602) 771-7882
ATTENTION: "MONITORING"

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. **POSITION** of nurse being evaluated:

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Staff Nurse | <input type="checkbox"/> Instructor | <input type="checkbox"/> Nurse Anesthetist |
| <input type="checkbox"/> Charge Nurse | <input type="checkbox"/> Supervisor | <input type="checkbox"/> Practitioner |
| <input type="checkbox"/> Other/describe: _____ | | |

3. **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: _____ | |

4. **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: _____

5. **QUALITY OF WORK**:

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

Comments: _____

CONTINUED ON BACKSIDE 

6. Does the nurse follow **POLICIES & PROCEDURES** (please comment)

- Exceptional Above Average
 Satisfactory Needs Improvement
 Comment: _____

7. If the nurse administers **MEDICATIONS**, or has access to MEDICATIONS have there been any errors or discrepancies (explain)

- Errors Discrepancies
 Comment: _____

8. Does the nurse demonstrate accuracy and adequacy in **DOCUMENTATION**:

- Exceptional Above Average
 Satisfactory Needs Improvement
 Comment: _____

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

- Very Good Satisfactory
 Needs Improvement
 Comment: _____

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

- Yes No
 Comment: _____

11. 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 #