

Louisiana State Board of Nursing

17373 Perkins Road

Baton Rouge, LA 70810

Telephone: (225) 755-7500 Fax: (225) 755-7583

<http://www.lsbns.state.la.us>

NURSING PERFORMANCE EVALUATION FOR: _____
(Month/Quarter) (Year)

RN Name _____ SSN _____

Facility: _____ Phone _____

Street Address _____ Immed Supv _____

City/State/Zip _____

Unit: _____ Phone: _____ Shift Worked: _____

Please rate by circling the appropriate number and provide comments in the space provided.
(Excellent = 5; Above Average = 4; Average = 3; Needs Improvement = 2; Poor = 1)

Work Habits

Rating

Comments

Completes Assignments 5-4-3-2-1

Handles Complex Tasks 5-4-3-2-1

Attendance 5-4-3-2-1

Absent Days ____ (With Explanation)

Tardy Days ____ (With Explanation)

Absent Days ____ (Without Explanation)

Tardy Days ____ (Without Explanation)

Job Efficiency

Rating

Comments

Follows Procedures 5-4-3-2-1

Problem Solving Ability 5-4-3-2-1

Managing Stressful Situations 5-4-3-2-1

Organizes/Plans Work 5-4-3-2-1

Thought Processes

Rating

Comments

Functions Independently 5-4-3-2-1

Uses Logical Steps in
Planning and Delivery Care 5-4-3-2-1

Interpersonal Relations

Rating

Comments

Works as a Team Member 5-4-3-2-1

Communications Skills 5-4-3-2-1

Drug Screens/Blood Alcohol Levels

Have screens been performed? (If Yes, please attach results.)

Yes _____ No _____

Comments _____

Has any job related behavior warranted requesting a screen? (If yes, please explain.)

Yes _____ No _____

Comments _____

Do you have any knowledge or belief that this employee is using a mood-altering chemical?

Yes _____ No _____ Unsure _____

Supervision

Does this person have direct on-site supervision at all times of employment?

Yes _____ No _____

Comments _____

What is the name of the direct on-site supervisor? _____

Additional Comments:

NOTE: If this is your first performance evaluation to complete, please indicate if you have "viewed" the Order of the Board: _____

Supervisor's Signature/Title _____ Date _____

Supervisor's Telephone Number _____

Reviewed with Nurse? Yes ___ No ___ If no, Explain _____

Nurse's Signature _____ Date _____

Please call the monitoring department (225)755-7546 to discuss any concerns or to receive clarification regarding this nurse's individual monitoring plan. Thank you.

Please mail form to:

RNP/Monitoring Department
Recovering Nurse Program Manager
Louisiana State Board of Nursing
17373 Perkins Road
Baton Rouge, LA 70810