Virginia Department of Health Professions
Board of Nursing

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Compliance - Nursing
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Performance Evaluation

This report covers only the current quarter of ***20*** _____*:* ☐ ***Jan-Mar*** *or* ☐ ***Apr-Jun*** *or* ☐ ***Jul-Sep*** *or* ☐ ***Oct-Dec***

To be timely, this report must be received from 5 days before until 5 days after the end date of the current quarter:
For example: if report is due 3/31, it must be received between 3/26 and 4/5.

FAXES & EMAIL ARE ACCEPTABLE – YOUR ORIGINAL SIGNATURE IS REQUIRED & MUST BE SUBMITTED AS WELL

The employee requesting that you complete this form is under an Order of the Virginia Board of Nursing. The Order is a public document that may be obtained online from the Board's webpage or on Nursys.com. This monitored person is Ordered to ensure timely submission of quarterly performance evaluations of them by you to Compliance, until released in writing from the Order.

Employee's Name: _____ License / Certificate / Registration #: _____

Date of Employment _____ Date Terminated/Resigned _____

Name and Position of Immediate Supervisor: _____

1. UNIT / TYPE OF CARE *(check all that apply)*

☐ Administrative	☐ ICU / Acute Care	☐ Private Duty
☐ Chemical Dependency	☐ Medical Surgical	☐ Psychiatry
☐ Contract Employee	☐ Nursing Home	☐ Self-Employed
☐ Emergency Department	☐ OB/GYN	☐ Staffing Agency
☐ Facility Employee	☐ OR/Recovery	☐ Other: _____
☐ Home Health	☐ Pediatrics	
☐ Hospital	☐ Primary Care	

2. POSITION / ROLE *(check all that apply)*

☐ Charge	☐ Medication Aide	☐ Supervisor
☐ Clinician	☐ Private Duty	☐ Other: _____
☐ Instructor	☐ Provider	
☐ Massage Therapist	☐ Staff	

3. SHIFT/HOURS WORK *(check all that apply)*

☐ Days ☐ Nights ☐ Evenings ☐ Full Time ☐ Part Time: # _____ hours worked each month

☐ PRN - list dates and hours worked this quarter: _____

4. ATTENDANCE *(respond to each question)*

Number of days absent in this quarter: _____. Pattern of absence exists? ☐ No ☐ Yes Explain below:

Number of days tardy in this quarter: _____. Pattern of tardiness exists? ☐ No ☐ Yes Explain below:

5. QUALITY OF WORK *(respond to each question)*

Date of employer's last Performance Evaluation: _____. Performance this quarter has been:

☐ Excellent ☐ Satisfactory ☐ Needs Improvement ☐ Unsatisfactory - ***Explain below***:

Has an evaluation or counseling session been held with the employee in the past 3 months?

☐ No ☐ Yes ☐ Written: ***Provide Copy & Explain below*** ☐ Verbal: ***Explain below:***

Have there been any incident reports, complaints, or concerns reported about this employee?

☐ No ☐ Yes: ***Provide copy & Explain below:***

6. MEDICATION DUTIES *(respond to each question)*

Does this employee administer medications? ☐ Yes ☐ No.

- If yes:
  - As a: ☐ CNA ☐ RMA ☐ Nurse ☐ Nurse Practitioner ☐ Other:
  - What types of drugs are administered? _____
  - Are there any restrictions? ☐ Yes ☐ No. If yes, what? _____
- If no, does the employee have access to medications? ☐ Yes ☐ No.

How often are medication records reviewed for accuracy? _____ ☐ Regularly ☐ Occasionally

Have you, or the employee's co-workers or patients/clients, seen evidence that the employee is **NOT** maintaining abstinence from all mood-altering chemicals, including alcohol and prescription medications? ☐ Yes ☐ No. ***Explain below:***

7. INTERPERSONAL RELATIONSHIPS

With clients/patients: ☐ Very Good ☐ Satisfactory ☐ Needs Improvement - ***Explain below:***

With the public: ☐ Very Good ☐ Satisfactory ☐ Needs Improvement - ***Explain below:***

With co-workers: ☐ Very Good ☐ Satisfactory ☐ Needs Improvement - ***Explain below:***

8. NOTIFICATION OF ORDER

Were you informed of the Consent Order/Order by the employee? ☐ Yes ☐ No. When?_____

Were you provided with a complete copy of the Consent Order/Order by the employee? ☐ Yes ☐ No. When?_____

If required by the Order, were you notified of Board approval for this employment? ☐ Yes ☐ No ☐ N/A.

If you answered no to any question in #8, please contact the Nursing Compliance Case Manager at the Board of Nursing. There may be restrictions on the nurse's practice.

Your cooperation is appreciated. Feel free to contact the Compliance Case Manager with any questions or concerns, or list them below.

Evaluator's Signature _____ Date _____

Title of Evaluator _____

Agency or Facility _____

Address _____

Email Address _____ Phone _____

EXPLANATIONS / QUESTIONS / CONCERNS / COMMENTS: