Reset Form

EMPLOYER QUARTERLY REPORT FOR A NURSE ON PROBATION

State Form 55844 (6-15)

INDIANA STATE BOARD OF NURSING
PROFESSIONAL LICENSING AGENCY
402 West Washington Street, Room W072
Indianapolis, Indiana 46204
Telephone: (317) 234-2043
E-mail: pla2@pla.IN.gov

The nurse who is requesting that you complete this form has been placed on probation by the Indiana State Board of Nursing. As a term of this probation, the nurse is to ensure that a quarterly employer report is submitted by the nurse's employer until the nurse is released from the Order. This form may be obtained from the Board's webpage (www.in.gov/pla) or by contacting the Compliance Office at Indiana Professional Licensing Agency at 317-234-2043.

Reporting period *(month, day, year)* From: To:	Report due *(month, day, year)*
Name of employee	License number
Name of employing facility	Telephone number ( )
Address *(number and street, city, state, and ZIP code)*	
Name of immediate supervisor	Title of immediate supervisor
Date of initial employment *(month, day, year)*	Position

ATTENDANCE

Number of hours practiced since the last reporting period: _____

Number of days absent since the past reporting period: _____

Number of days tardy since the last reporting period: _____

Explain reason for absences and/or tardiness.

Please answer the following questions and explain where appropriate.

Has there been a change in position or responsibilities since the last reporting period?	☐ Yes ☐ No
Have you identified any performance deficiencies? *If yes, please explain how those have been addressed below.*	☐ Yes ☐ No
To the best of your knowledge, do you believe this employee is maintaining abstinence from all mood altering chemicals, including alcohol?	☐ Yes ☐ No ☐ Not applicable
To the best of your knowledge, do you believe this employee is fully adhering to the agency's rules, policies, procedures, and duties as outlined in his/her job description?	☐ Yes ☐ No
Since the last report has the employee had any employment disciplinary concerns, incident reports, concerns reported about this nurse, or corrective action?	☐ Yes ☐ No

Comments and explanations:

EVALUATION OF EMPLOYEE					
E = Excellent S = Satisfactory NI = Needs improvement (explain)					
FACTORS	**E**	**S**	**NI**	**STRENGTHS**	**OPPORTUNITIES FOR IMPROVEMENT**
Adherence to Facilities Policies and Procedures	☐	☐	☐		
Assessment Skills	☐	☐	☐		
Attendance/Punctuality	☐	☐	☐		
Communication Skills	☐	☐	☐		
Cooperation/Attitude	☐	☐	☐		
Documentation Skills	☐	☐	☐		
General Appearance	☐	☐	☐		
Medication Administration	☐	☐	☐		
Quality of Patient Care	☐	☐	☐		
Supervision/Delegation	☐	☐	☐		
Work Relationships with Coworkers	☐	☐	☐		
Overall Performance	☐	☐	☐		

MEDICATION DUTIES		
Does this employee administer medications?	☐ Yes	☐ No
Are there any restrictions to what medication this employee can administer?	☐ Yes	☐ No
Does this nurse have access to medications?	☐ Yes	☐ No
How often is medication records reviewed for accuracy?		
Have any discrepancies been discovered? *If yes please explain.*	☐ Yes	☐ No

NOTIFICATION OF BOARD ORDER		
Were you informed of the Board Order by the nurse?	☐ Yes	☐ No
Were you provided with a COMPLETE copy of the Board Order by the nurse?	☐ Yes	☐ No
Did you sign a copy of the Board Order and return it to the Indiana State Board of Nursing?	☐ Yes	☐ No

SIGNATURE OF SUPERVISOR	
Signature of Supervising Nurse	Date signed *(month, day, year)*
Title	Telephone number ( )

Please send completed form along with a cover letter on company letterhead to:

Indiana State Board of Nursing
402 W. Washington Street, RM W072
Indianapolis, IN 46204
Or
By E-mail: probation2@pla.in.gov

Your cooperation regarding this matter is greatly appreciated.