

**ARKANSAS STATE BOARD OF NURSING
1123 SOUTH UNIVERSITY, SUITE 800
LITTLE ROCK, ARKANSAS 72204
(501) 686-2700**

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)

Medical/Surgical	OB/GYN	Home Health	Critical Care
Nursery	Nursing Home	Emergency Room	Pediatrics
Behavioral Health	OR/Recovery Room	Chemical Dependency	

Other/describe: _____

2. POSITION of nurse being evaluated:

Staff Nurse	Instructor	Nurse Anesthetist	Charge Nurse
Supervisor	Practitioner	Other/describe: _____	

3. SCHEDULE: (check all that may apply)

Days 7 - 3	Part-time	12-hour shifts
Evenings 3 - 11	Full-time	Varied
Nights 11 - 7	Other/describe: _____	

4. SUPERVISION: Complete Only if the Board's Order requires this nurse to work under direct supervision. Direct Supervision requires another nurse to be working in the same setting and to be readily available to provide assistance and intervention.

Working under the supervision of: (specify name or describe position of person who is supervising)

5. 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 – Describe: _____

does not exist.

