Coordinator:

KS Board of Nursing Work Performance Evaluation

Participant: _____ Position Title: _____
Month(s), Year Evaluated: _____, _____ Date of Hire:
Licensee's is a participant in the (check one) ☐ Alternative Program for Chemical Dependency
☐ Chemical Dependency Discipline Program ☐ Probation License – Drug Screening
As a condition, Work Performance Evaluations completed by the clinical supervisor are due as scheduled to:

Compliance Coordinator
900 SW Jackson, Ste 1051 Topeka, KS 66612-1230
Fax: 785-296-3929

Clinical Supervisor: _____
Phone(s): _____ Email: _____
Facility: _____ Unit: _____
Status (check one): ☐ Part-Time ☐ Full-Time ☐ PRN
Shift (check all that apply): ☐ Days ☐ Evenings ☐ Nights ☐ Rotate
Hours Worked Per Week: _____ **Must average 64h worked per month for work to satisfy conditions of program.*
Quality of work: ☐ Satisfactory ☐ Needs improvement* ☐ Unsatisfactory*
*Please explain:

Does the Licensee administer or have access to controlled substances? ☐ YES ☐ NO
If YES, have there been errors or discrepancies? ☐ YES ☐ NO
If YES, please explain:

To the best of your knowledge, since the last evaluation, has the nurse:

- Changed Work Location	☐ YES	☐ NO
- Changed Shift	☐ YES	☐ NO
- Changed Hours Scheduled	☐ YES	☐ NO
- Changed Position	☐ YES	☐ NO
- Changed Supervisor	☐ YES	☐ NO
- Used drugs or alcohol	☐ YES	☐ NO
- Been counseled (including conference, oral or written)	☐ YES	☐ NO

If YES to any of the above, please explain and provide copy of counseling (if applicable):

Are you aware of the reasons the KS Board of Nursing is requiring evaluations? ☐ YES ☐ NO

_____ _____
(Signature and Title of Approved Clinical Evaluator) Date