

KANSAS STATE BOARD OF NURSING - NURSING PERFORMANCE REPORT FORM

The nurse/licensee requesting completion of this form is doing so to comply with requirements of the Kansas State Board of Nursing. The nurse/licensee is required to submit to the Board a nursing performance report prepared by his or her immediate supervisor or by an RN who evaluates the nurse's/licensee's performance on a regular basis. The nurse/licensee has been provided with due dates for the reports. This report may be disclosed via a Kansas Open Records Act request. This report is to be mailed directly to the Board by the reporter. Legal Division, Kansas State Board of Nursing, Landon State Office Building, 900 SW Jackson, Ste. 1051, Topeka, KS 66612-1365.

Licensee Information

Name: _____ License#: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Telephone: _____ Daytime Telephone: _____

Reporter Information

Name/Credentials: _____ License#: _____

LICENSEE'S AREA OF PRACTICE

- Medical/Surgical ICU Psychiatry
- Chemical Dependency OB/Gyn OR/Recovery
- Emergency Room Pediatrics Nursing Home
- Private Duty Nurse Anesthetist Other: _____

LICENSEE'S POSITION

- Supervisor Instructor Charge Nurse
- Private Duty Staff Other: _____

Does the licensee work without supervision? Yes No

If yes, explain below.

LICENSEE'S SHIFT/HOURS OF WORK

- Days Evenings Nights
- PRN Full Time: hrs/wk _____ Part Time: hrs/wk _____

LICENSEE'S ATTENDANCE

Number of days absent since last report _____ Number of days tardy since last report _____

LICENSEE'S QUALITY OF WORK

- Excellent Satisfactory Needs Improvement Unsatisfactory

Has a counseling session been held regarding the licensee since the last report? Yes No

If yes, provide a copy and explain below.

Have there been incident reports/complaints about the licensee since the last report? Yes No

If yes, provide a copy and explain below.

Does the licensee meet standards regarding facility policies and procedures? Yes No

If no, explain below.

LICENSEE'S CONTACT WITH MEDICATIONS/NARCOTICS

Does the licensee administer medications? Yes No

Does the licensee administer narcotics/mood altering drugs? Yes No

Does the licensee accept delivery of narcotics/mood altering drugs to the facility? Yes No

Does the licensee participate in the counting of narcotics/mood altering drugs? Yes No

LICENSEE'S INTERACTIONS WITH PATIENTS

Excellent Satisfactory Needs Improvement Unsatisfactory

Does the licensee have direct patient contact? Yes No

LICENSEE'S INTERACTIONS WITH STAFF AND ADMINISTRATION

Excellent Satisfactory Needs Improvement Unsatisfactory

*PLEASE PROVIDE EXPLANATIONS OR COMMENTS BELOW. USE ADDITIONAL SHEETS IF NEEDED.
THANK YOU FOR YOUR PARTICIPATION.*

Signature and Title of Reporter

Date

Agency/Facility

Telephone Number

Mailing Address of Agency/Facility