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Ohio Board of Nursing *www.nursing.ohio.gov*
17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

WORK PERFORMANCE EVALUATION FORM

Please submit this form directly to the Ohio Board of Nursing's Alternative Program for Chemical Dependency/Substance Use Disorders by mail or by fax (#614-466-0710).

Participant Name: _____ Participant's Job Title: _____

Work Site Monitor and Title: _____

Facility: _____ Telephone No.: _____

Unit/Department: _____ Shift Worked: _____

Evaluation for the month/year of: _____

Please rate the Participant's employment performance using the scale indicated below:
5= Excellent and 1= Poor.

WORK HABITS	**RATING (circle one)**	**COMMENTS**
Attendance/Punctuality	5—4—3—2—1	
Completes assignments	5—4—3—2—1	
JOB EFFICIENCY	**RATING (circle one)**	**COMMENTS**
Follows policies & procedures	5—4—3—2—1	
Effectively organizes/plans work	5—4—3—2—1	
Handles complex tasks	5—4—3—2—1	
Utilizes problem solving ability	5—4—3—2—1	

Manages stressful situations	5—4—3—2—1	
THOUGHT PROCESS	**RATING (circle one)**	**COMMENTS**
Functions independently	5—4—3—2—1	
Uses logical steps in planning care	5—4—3—2—1	
INTERPERSONAL SKILLS	**RATING (circle one)**	**COMMENTS**
Works as a team member	5—4—3—2—1	
Effectively communicates	5—4—3—2—1	

Has this participant received counseling/disciplinary action since the last report?
YES ____ NO ____ If YES, please attach a **certified copy** of the documentation and/or corrective plan.

As an employer, have you requested a drug screen from the Participant?
YES ____ NO ____

If a drug screen was requested, what was the result of the drug screen?

_____

Why was the drug screen requested?

_____

Additional Comments:

_____
_____
_____
_____
_____

_____ _____
Work Site Monitor Signature Date

If employment is terminated, please immediately notify the Board or Monitoring Agent.

Effective April 2015