

# Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935  
Madison, WI 53708-8935

FAX #: (608) 266-2264  
Phone #: (608) 267-3817

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Madison, WI 53703

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## MONITORING

### NURSING WORK REPORT FORM

If you have any questions regarding this report, please contact the Monitor at 608-267-3817.  
Please provide as much detail as possible (use back of page or additional sheets, if necessary).

Employee's Name: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Type of Facility: \_\_\_\_\_

Date of Employment: \_\_\_\_\_ Length of Employment: \_\_\_\_\_

Full-time       Part-time      Number of hours per week: \_\_\_\_\_

Shift:               Days       Evenings       Nights       Rotates

Attendance: Number of days absent in the past three months: \_\_\_\_\_

No pattern of absence       Pattern of absence Describe: \_\_\_\_\_

Number of days tardy in the past three months: \_\_\_\_\_

No pattern of tardiness       Pattern of tardiness Describe: \_\_\_\_\_

Quality of Work:  Outstanding       Satisfactory       Needs Improvement

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Interpersonal relationships with co-workers:

Very good       Satisfactory       Needs Improvement

Comments: \_\_\_\_\_

\_\_\_\_\_

Individual evaluation conference held in past three months?       Yes       No

Outcome: \_\_\_\_\_

\_\_\_\_\_

Has this employee provided his/her immediate supervisor with a copy of the Board's Final Decision and Order and any subsequent orders in a timely manner?       Yes       No

If no, please explain: \_\_\_\_\_

To the best of your knowledge has the licensee been in compliance with the terms of his/her Order.

Yes       No

If no, please explain: \_\_\_\_\_

\_\_\_\_\_

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To the best of your knowledge has the licensee been in compliance with the laws and rules governing the practice of the profession?             Yes             No

If no, please explain: \_\_\_\_\_  
\_\_\_\_\_

Is this employee administering medications?             Yes             No

If the employee is administering medications, have any problems or discrepancies been noted?

Please describe: \_\_\_\_\_  
\_\_\_\_\_

**If employee has an alcohol/drug impairment, please answer these additional questions:**

Is this employee administering controlled substances?             Yes             No

If the employee is administering controlled substances, have any problems or discrepancies been noted? Please describe: \_\_\_\_\_  
\_\_\_\_\_

Does this employee have access to controlled substances?             Yes             No

If Yes, please describe the nature of the access (ex. direct or indirect; limited; supervised or unsupervised).  
\_\_\_\_\_

To the best of your knowledge, do you believe the employee is maintaining abstinence from all mood altering chemicals, including alcohol?             Yes             No             Unsure

If you answered No or Unsure, please explain: \_\_\_\_\_  
\_\_\_\_\_

Any further comments, questions or problems? (Please attach additional sheets)

\_\_\_\_\_  
Signature of Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Supervisor and Title

\_\_\_\_\_  
Supervisor's License Number

\_\_\_\_\_  
Supervisor's Place of Employment

\_\_\_\_\_  
Address

(    ) \_\_\_\_\_  
Phone number

Please feel free to attach any additional information you wish to bring to the Monitor's attention.

Please mail or fax this form every three months to:

**ATTN: Department Monitor  
Wisconsin Department of Safety and Professional Services  
PO Box 8935  
Madison, WI 53708-8935  
Fax (608) 266-2264**