Work Performance Evaluation (WPE)

To be completed by participant's immediate supervisor

Case # _____Participants Name: _____

Facility _____

Mailing address of facility _____

City, State, Zip _____

Immediate Supervisor:_____Credentials:_____

Supervisor # _____ Supervisor email: _____

Complete the below with information regarding the participant:

Unit _____ Shift _____ Position_____

Employment Type: ___ Full Time___ Part Time___ Internships/Volunteer___ On -call/ Per Diem

Please rate by selecting the appropriate number and provide comments in space provided.

	Poor				Excellent
1. Attendance:	1	2	3	4	5
2. Punctuality:	1	2	3	4	5
3. Professional in Appearance:	1	2	3	4	5
4. Adheres to work place policies/ procedures	1	2	3	4	5
5. Exhibits appropriate decision making skills:	1	2	3	4	5
6. Work Performance:	1	2	3	4	5
7. Behavior when interacting with peers and patients:	1	2	3	4	5

Have any worksite drug screens been performed this period? *Yes ____ No____

*If yes please list reason: _____

Did the participant work in nursing a minimum of twelve (12), eight (8) hour shifts this quarter as required? Yes____No___

A current copy of the Monitoring Contract should have been provided by the employee.

Has this contract been provided? Yes ____ No____

Are you aware of and do you understand the employee's current work conditions and restrictions?

Yes ____ No____

Comments:

_____

_____

_____

(Please print)

Supervisor Name _____**Title/Position** _____

Signature _____ **Date** _____

Reviewed with participant? Yes___ No___ If yes, participant's signature _____

Please provide your e-mail address for our records. Each quarter you will be sent an e-mail with instructions on how to fill this report out online.

Please call the IPN Office at 1-800-840-2720 to discuss any concerns or clarification regarding this nurse's individual monitoring plan. Thank you

Please return this form by fax 904-270-1633 or Mail to: IPN, P.O. Box 49130, Jacksonville Beach, FL 32240-9130

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