



Commonwealth of Massachusetts
 Department of Public Health
 Bureau of Health Professions Licensure
Board of Registration in Nursing
 239 Causeway Street • Boston, Massachusetts 02114
SUPERVISION REPORT FOR NURSES ON PROBATION
WITH THE BOARD OF REGISTRATION IN NURSING

(Please review the nurse’s Probation Agreement or Order and complete this evaluation of the nurse’s practice)

Nurse’s Name: _____ Docket No.: _____

License Type and No.: _____ Expiration Date _____

Nurse’s Job Title: _____

Employer Name and Address: _____

Time period covered by this supervision report: Start Date: _____ to End Date: _____

Rate the following and explain any “Does Not Meet”/“Needs Improvement” ratings (use the “Comments” column and if needed the back of this form or include on supervisor’s signed cover letter on facility letterhead).

Quality being rated	Does Not Meet	Meets	Comments
Organizes and plans work effectively	<input type="checkbox"/>	<input type="checkbox"/>	
Completes assignments	<input type="checkbox"/>	<input type="checkbox"/>	
Works as a team member	<input type="checkbox"/>	<input type="checkbox"/>	
Communicates effectively	<input type="checkbox"/>	<input type="checkbox"/>	
Seeks guidance and supervision appropriately	<input type="checkbox"/>	<input type="checkbox"/>	
Interacts with patients in a therapeutic manner	<input type="checkbox"/>	<input type="checkbox"/>	
Demonstrates problem solving ability	<input type="checkbox"/>	<input type="checkbox"/>	
Manages stressful situations appropriately	<input type="checkbox"/>	<input type="checkbox"/>	
Makes timely and appropriate nursing assessments	<input type="checkbox"/>	<input type="checkbox"/>	
Makes appropriate nursing interventions	<input type="checkbox"/>	<input type="checkbox"/>	
Delegates nursing care activities appropriately	<input type="checkbox"/>	<input type="checkbox"/>	
Removes, handles, wastes, and accounts for the whereabouts of, medications appropriately	<input type="checkbox"/>	<input type="checkbox"/>	
Documents controlled substances and medication administrations accurately and completely	<input type="checkbox"/>	<input type="checkbox"/>	
Documents nursing care and interventions accurately and completely	<input type="checkbox"/>	<input type="checkbox"/>	
Other practice skill(s) specified by Probation Agreement or Order	<input type="checkbox"/>	<input type="checkbox"/>	

**SUPERVISION REPORT FOR NURSES ON PROBATION WITH
THE BOARD OF REGISTRATION IN NURSING (continued)**

The nurse HAS HAS NOT (please choose one and do not leave any blanks) worked an average of at least twenty (20) hours per week during the time period covered by this report.

SUPERVISION

How frequently is the nurse supervised? _____

How is supervision provided? _____

Have there been any incidents involving the nurse requiring counseling, conference, oral/written warnings since last report? If yes, please explain and attach copies of all relevant documents.

How often are the nurse's patient records reviewed? _____

Does this nurse have any other nursing practice issues? Explain. _____

ADDITIONAL COMMENTS are appreciated

(If needed, please use the back of this form or include on supervisor's signed cover letter on facility letterhead)

Please call the Probation Monitor at (617)973-0951 (alternate #: 617-973-0828) to discuss any concerns or for clarification regarding the nurse's probation.

SUPERVISOR'S SIGNATURE: _____ DATE SIGNED _____

(Print/Type: Name and Title of Supervisor completing this form)

Supervisor's License Type and No.: _____ Supervisor Phone No.: _____

PLEASE NOTE CAREFULLY:

**This fully completed form must be mailed *with* the supervisor's signed cover letter written on the facility's letterhead directly to: Probation Monitor
DPH – DHPL, Board of Registration in Nursing
239 Causeway Street, 5th Floor
Boston, MA 02114**