



Commonwealth of Massachusetts  
 Department of Public Health  
 Bureau of Health Professions Licensure  
**Board of Registration in Nursing**  
 250 Washington, Boston, Massachusetts 02108  
**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" 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 Compliance Officer at (617) 973-0863 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 Compliance Officer  
DPH – BHPL, Board of Registration in Nursing  
250 Washington Street  
Boston, MA 02108**