



The Commonwealth of Massachusetts
Department of Public Health
Bureau of Health Professions Licensure

Board of Registration in Nursing
239 Causeway Street • Boston, Massachusetts 02114

Substance Abuse Rehabilitation Program
Nursing Supervisor Report

(Please review the SARP Treatment Contract and complete this evaluation of the nurse's practice)

Name of Nurse in SARP _____
License Type and No. _____ SARP Reference No. _____
Effective Date of the SARP Treatment Contract: _____
Nurse's Date of Employment: _____
Employer Name and Address: _____

Time period covered by this supervision report (start and end date): _____

Rate the following and explain as necessary.

| Attendance |
|--|
| In the previous 3 months the nurse has been absent how many days? _____ |
| Did the nurse provide you with a reasonable excuse for these absences? YES ___ NO ___ |
| Did the nurse require any administrative action as a result of these absences? If yes, please explain: |
| Tardiness |
| In the previous 3 months the nurse has been tardy how many times? _____ |
| Did the nurse provide you with a reasonable excuse for this tardiness? YES ___ NO ___ |
| Did the nurse require any administrative action as a result of this tardiness? If yes, please explain: |
| Relationship with Others |
| In the previous 3 months the nurse has maintained appropriate professional relationships with: Peers: YES ___ NO ___ Supervisors: YES ___ NO ___ Patients/residents: YES ___ NO ___ Families/others: YES ___ NO ___ If no to any of the above, please explain |
| Nursing Practice |

***Please keep a copy for your records**

In the previous 3 months the nurse has:

1. Demonstrated overall expectations of the nursing role: YES ___ NO ___
2. Followed policies and procedures: YES ___ NO ___
3. Demonstrated accuracy in documentation: YES ___ NO ___
4. Exercised reasonable clinical judgment: YES ___ NO ___
5. Sought supervision when necessary: YES ___ NO ___
6. Demonstrated reasonable problem solving abilities: YES ___ NO ___
7. Completed assignments on time: YES ___ NO ___
8. For nurses with medication administration privileges; has the nurse administered medications without incident: YES ___ NO ___. If no, please explain:

Abstinence

In the previous 3 months how would you describe the nurse's mood?

Good ___ Fair ___ Poor ___

In the previous 3 months how would you describe the nurse's appearance?

Good ___ Fair ___ Poor ___

In the previous 3 months, and to the best of your knowledge, has the nurse maintained abstinence? YES ___ NO ___. If No, please explain:

Practice Restrictions – *Check all that apply

- No nursing practice
- Practice in a structured, supervised setting
- No passage of, or access to, medications
- No passage of, or access to, controlled substances, Classes II-V
- No participation in the narcotic count, no access to keys, code etc.
- May not work with IVs containing controlled substance drugs
- Not to work in high stress/high access area
- Work up to 40 hours: day evening night shifts
- No floating
- No rotating of shifts, not to work a shift within 12 hours of the previous shift; will not double back
- May work up to _____ hours of overtime
- Other: _____

ADDITIONAL COMMENTS

(If needed, please attach additional sheet and indicate below)

Please call the SARP Coordinator at (617)973-0800 to discuss any concerns or for clarification regarding the nurse's treatment contract.

SUPERVISOR'S SIGNATURE: _____ DATE SIGNED _____

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

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