



Mental Health Professional Supervisor Report

(Please duplicate this form for future use)

Date: _____

Licensee: _____

Report for the period beginning _____ and ending _____

Please attach explanation for any false answers.

- | True | False | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. This licensee is employed in a capacity for which a license is required by statute. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. The licensee is working _____ (number of) hours per week. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Supervision is provided by another licensed professional who has no license restrictions. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. The supervisor notified Peer Assistance Services, Inc. by telephone within 72 hours after the commencement <u>or</u> termination of employment. |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. In the supervisor's opinion, this licensee is practicing consistent with standards of practice. |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. This licensee is dispensing/administering narcotics or mind altering drugs (e.g., benzodiazepines or sleeping medications) that are prone to abuse. |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. The supervisor has not noted evidence of alcohol or other substance use. |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Supervisor received copy of Contract and stipulation (if applicable). |

Please describe the duties and responsibilities to be carried out by the Licensee. Please attach current job description. _____

Please describe the type of direct supervision provided: _____

Licensee: _____

BEHAVIORAL PERFORMANCE GUIDELINES - All employees, at some time, display job performance problems. An isolated incident of coming to work late need not be a cause for alarm. However, when a Licensee displays a pattern of repeated job performance decline, the supervisor needs to take notice and report it to Peer Assistance Services, Inc. Use the checklist below to determine if there are job performance problems.

Decline in Job Efficiency

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Decrease in overall work quality |
| <input type="checkbox"/> | <input type="checkbox"/> | Inconsistent work quality (periods of high and/or low productivity) |
| <input type="checkbox"/> | <input type="checkbox"/> | Errors in judgment |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased period of confusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of concentration |
| <input type="checkbox"/> | <input type="checkbox"/> | Unrealistic excuses for lowered work quality |
| <input type="checkbox"/> | <input type="checkbox"/> | Missed deadlines |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased carelessness/mistakes |
| <input type="checkbox"/> | <input type="checkbox"/> | Tasks taking excessive time to complete or never being completed |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty handling complex tasks |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory |

Inconsistent Work Patterns

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Alternate periods of high and low efficiency |
| <input type="checkbox"/> | <input type="checkbox"/> | Becoming or has become less dependable |
| <input type="checkbox"/> | <input type="checkbox"/> | Doing minimal or substandard work in comparison with peers |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent requests for help with assignments |

Absenteeism

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Repeated absenteeism (above average) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pattern of Monday and Friday absenteeism or absenteeism centered around scheduled days off |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive tardiness (Monday and Friday) or after days off |
| <input type="checkbox"/> | <input type="checkbox"/> | Leaving work early |
| <input type="checkbox"/> | <input type="checkbox"/> | Repeated absenteeism due to vaguely defined illnesses, "not feeling well," "cold," "headache" |
| <input type="checkbox"/> | <input type="checkbox"/> | Improbable reasons for absenteeism |
| <input type="checkbox"/> | <input type="checkbox"/> | Unauthorized leave |
| <input type="checkbox"/> | <input type="checkbox"/> | Last minute request for leave |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive use of sick leave |

On-the-Job Absenteeism

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Extended lunch breaks |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical illnesses developed on the job |
| <input type="checkbox"/> | <input type="checkbox"/> | Unexplained disappearances on the job (never finding him/her when needed) |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive breaks, trips to bathroom or to water fountain |
| <input type="checkbox"/> | <input type="checkbox"/> | Vacant look on the job |

Licensee: _____

Attitude/Mood

- | Yes | No | |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Dramatic mood shifts |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendency to isolate |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> | Secretiveness/suspiciousness |
| <input type="checkbox"/> | <input type="checkbox"/> | Crying |
| <input type="checkbox"/> | <input type="checkbox"/> | Inflexibility |

Physical/Emotional Problems

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Changes in physical/emotional condition during shift |
| <input type="checkbox"/> | <input type="checkbox"/> | Marked nervousness on the job |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive sweating |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremors of hands |
| <input type="checkbox"/> | <input type="checkbox"/> | Lack of attention to personal cleanliness or grooming |
| <input type="checkbox"/> | <input type="checkbox"/> | Reports to duty despite physical/emotional contraindication |

Impaired Interpersonal Relationships

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent arguments with co-workers |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive blaming of others |
| <input type="checkbox"/> | <input type="checkbox"/> | Unwillingness to cooperate with co-workers or inability to compromise |
| <input type="checkbox"/> | <input type="checkbox"/> | Over-reactions to co-workers |
| <input type="checkbox"/> | <input type="checkbox"/> | Wide swings in mood from isolation to angry outbursts |
| <input type="checkbox"/> | <input type="checkbox"/> | Avoids contact with supervisor |
| <input type="checkbox"/> | <input type="checkbox"/> | Complaints by patient or co-workers of irritability, physical roughness, or verbal abuse |

Other Areas

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive time spent making personal telephone calls |
| <input type="checkbox"/> | <input type="checkbox"/> | Physically threatening |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive talkativeness |
| <input type="checkbox"/> | <input type="checkbox"/> | Grandiosity (exaggerated self-importance) |

Difficulty in Concentration

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Assignment takes more time (despite skill/experience) |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in assigning priorities |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication errors (wrong medication, wrong dose, administration to wrong patient) |
| <input type="checkbox"/> | <input type="checkbox"/> | Omitted, illogical, incomplete, or illegible charting |
| <input type="checkbox"/> | <input type="checkbox"/> | Deteriorating handwriting during shift or deteriorating performance |
| <input type="checkbox"/> | <input type="checkbox"/> | Errors in transcribing orders or taking verbal orders |
| <input type="checkbox"/> | <input type="checkbox"/> | Overlooking signs of a patient's deteriorating condition |

Licensee: _____

Medication Centered Problems

Yes No

- Increased utilization of p.r.n. psychoactive medications or narcotics recorded for patients
- Increase in wastage or breakage of psychoactive drugs
- Missing drugs or unaccounted doses
- Seeks out on-duty physicians to "fix" complaints of pain, backache, migraines, etc.

Comment on any areas checked: _____

Please note in narrative form any changes that you have observed in this employee since they have participated in the Peer Assistance Program: _____

Any knowledge or concern regarding this licensee's inability to practice with reasonable skill and safety must be reported to Peer Assistance Services, Inc. within 24 hours at 303-369-0039.

Supervisor Signature

Date

Supervisor Name (Please Print)

Employer

Address

City, State, Zip

Phone #

**Mail Original To: Peer Assistance Services, Inc.
 2170 S. Parker Road, Suite 229
 Denver, CO 80231
 Phone: 303.369.0039 or 866.369.0039
 Fax: 720.213.1007**