INDIANA STATE NURSES ASSISTANCE PROGRAM
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www.IndianaNurses.org

WORKSITE MONITOR'S QUARTERLY REPORT

Thank you for your assistance with monitoring. Your input is invaluable to ISNAP. Please be assured that this form is confidential and not available to anyone outside of the monitoring program.
Thank you for your cooperation.

Licensee's Name: ____________________

Months of: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Year: __________
(Please circle the 3 months of the Quarter)

Employer: ____________________

Unit/Area of Practice: ____________ Shift: __________ Hrs/Week: ________

How often do you have contact with Licensee on a weekly basis? ____________

1. Have there been any problems with this nurse during the last quarter?

Inability	☐ No	☐ Yes	Irresponsibility	☐ No	☐ Yes
Inaccessibility	☐ No	☐ Yes	Irritability	☐ No	☐ Yes
Incidentals	☐ No	☐ Yes	Isolation	☐ No	☐ Yes

2. Does Licensee have Narcotic Restrictions? ☐ No ☐ Yes

   If YES – Has Licensee: Passed Wasted Counted **ANY** narcotics? Please Circle Answer(s)

3. Has the nurse notified you of any changes in his/her medications?
   Prescription ☐ No ☐ Yes OTC ☐ No ☐ Yes

4. Any Additional Comments? ☐ No ☐ Yes Please Circle Answer(s)

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5. Would you like someone from ISNAP to contact you? ☐ No ☐ Yes

Worksite Monitor's Name: ____________________ Contact #: __________

______________________________ ______________
Worksite Monitor's Signature: Date:

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