Iowa Nurse Assistance Program (INAP)

Offered by the Iowa Board of Nursing
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WORKSITE MONITOR (WSM) QUARTERLY REPORT

REPORTS ARE DUE IN DECEMBER, MARCH, JUNE, AND SEPTEMBER OF EACH QUARTER

Participant Name: _____

Worksite Monitor Name (print): _____

Professional Relationship to Participant: _____

Workplace Name: _____ Phone Number: _____

Address: _____

Worksite Monitor (signature): _____ Date: _____

Report Period: ☐ December ☐ March ☐ June ☐ September

Year: _____

Rate the following factors as they pertain to the participant's performance at the workplace.

Circle the appropriate number for each factor (1-5), where 1= Poor & 5=Excellent

Factor	Rating				
Recordkeeping (timeliness/accuracy)	1	2	3	4	5
Punctuality	1	2	3	4	5
Professional demeanor (with clients/patients)	1	2	3	4	5
Professional demeanor (with colleagues/staff)	1	2	3	4	5
Overall work quality	1	2	3	4	5

Have this participant's responsibilities changed since the last quarter?: ☐ Yes ☐ No

If yes, please explain: _____

_____

Does this participant appear to be practicing in a safe and competent manner? ☐ Yes ☐ No

If no, please contact INAP.

Additional Comments (use back, if necessary): _____

_____

For more information about INAP or to download forms, please visit our website:
https://nursing.iowa.gov/iowa-nurse-assistance-program

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