

**ST. JOSEPH SCHOOL OF NURSING**  
**5 Woodward Avenue, Nashua, NH 03060**  
**(603) 594-2567**

**EMPLOYER**  
**CLINICAL PROFICIENCY EVALUATION**  
**(For use by LPN applying to ASN program)**

Date: \_\_\_\_\_ Applicant's Name: \_\_\_\_\_

Number of Years Employed as an LPN: \_\_\_\_\_

Current Place of Employment: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone Number: \_\_\_\_\_

Start Date: \_\_\_\_\_ Current Position: \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_

**TO BE COMPLETED BY YOUR CURRENT SUPERVISOR:**

Please complete the questions below pertaining to the above named applicant to St. Joseph School of Nursing's ASN program.

How long have you been supervisor to the above named individual: \_\_\_\_\_

How would you rate the following?	LOW				HIGH
	1	2	3	4	5
Punctuality					
Attendance					
Teamwork					
Communication Skills					
Assessment Skills					
Nursing Diagnosis Assessment					
Planning (patient outcomes & nursing interventions)					
Implementation of Nursing Skills					
Maintains Safe Environment					
Role as Patient Advocate					

Additional Comments: \_\_\_\_\_

Signature: \_\_\_\_\_ Credentials: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ E-mail: \_\_\_\_\_