



# EMPLOYER REPORT FOR A LICENSEE ON PROBATION

State Form 9900399 (R1-02/26)

**INDIANA PROFESSIONAL LICENSING AGENCY**  
 402 West Washington Street, Room W072  
 Indianapolis, Indiana 46204  
 Telephone: (317) 232-2960  
 E-mail: [probation@pla.in.gov](mailto:probation@pla.in.gov)  
[www.pla.in.gov](http://www.pla.in.gov)

### INSTRUCTIONS:

1. Complete the form below for each quarter as licensee remains under probation.
2. Please upload the completed form to licensee's online portal at [mylicense.in.gov/eGov/ML1PLA.html](http://mylicense.in.gov/eGov/ML1PLA.html) along with a cover letter on company letterhead.
3. Select the "Upload Discipline Documents" action item on either the "Linked License(s)" or "Submitted Pending Application".
4. Failure to timely upload the form or failure to provide correct information is a violation of probation terms and can result in additional disciplinary proceedings.
5. Please update any change in contact information in MyLicense One.

Reporting period (month, day, year) From: _____ To: _____		Report due (month, day, year)
Name of employee		License number
Name of employing facility		Telephone number (     )
Address (number and street, city, state, and ZIP code)		
Name of immediate supervisor		Title of immediate supervisor
Date of initial employment (month, day, year)	Position	

### ATTENDANCE

Number of hours practiced since the last reporting period: \_\_\_\_\_

Number of days absent since the past reporting period: \_\_\_\_\_

Number of days tardy since the last reporting period: \_\_\_\_\_

Explain reason for absences and/or tardiness.

### Please answer the following questions and explain where appropriate.

Has there been a change in position or responsibilities since the last reporting period?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you identified any performance deficiencies? <i>If yes, please explain how those have been addressed below.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
To the best of your knowledge, do you believe this employee is maintaining abstinence from all mood-altering chemicals, including alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
To the best of your knowledge, do you believe this employee is fully adhering to the agency's rules, policies, procedures, and duties as outlined in his/her job description?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Since the last report has the employee had any employment disciplinary concerns, incident reports, concerns reported about this licensee, or corrective action?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Comments and explanations:

**EVALUATION OF EMPLOYEE**

*E = Excellent    S = Satisfactory    NI = Needs improvement (explain)*

<b>FACTORS</b>	<b>E</b>	<b>S</b>	<b>NI</b>	<b>STRENGTHS</b>	<b>OPPORTUNITIES FOR IMPROVEMENT</b>
Adherence to Facilities Policies and Procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Assessment Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Attendance/Punctuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Communication Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cooperation/Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Documentation Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Medication Administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Quality of Patient Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Supervision/Delegation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Work Relationships with Coworkers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Overall Performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

**MEDICATION DUTIES**

Does this employee administer medications?  Yes  No

Are there any restrictions to what medication this employee can administer?  Yes  No

Does this employee have access to medications?  Yes  No

How often is medication records reviewed for accuracy?

Have any discrepancies been discovered? *If yes please explain.*

Yes  No

**NOTIFICATION OF BOARD ORDER**

Were you informed of the Board Order by the licensee?

Yes  No

Were you provided with a COMPLETE copy of the Board Order by the licensee?

Yes  No

Did you sign a copy of the Board Order and return it to the Indiana Professional Licensing Agency?

Yes  No

**SIGNATURE OF SUPERVISOR**

Signature of Supervisor

Date signed (*month, day, year*)

Title

Telephone number  
(     )