



MSN Nurse Anesthesia Program Applicant Evaluation By Nursing Supervisor

Section One: To be completed by applicant. Please type or print.

Applicant: _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Last First Middle </div>	<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">X</td> <td style="width: 20px; height: 20px; text-align: center;">X</td> <td style="width: 20px; height: 20px; text-align: center;">X</td> <td style="width: 20px; height: 20px; text-align: center;">-</td> <td style="width: 20px; height: 20px; text-align: center;">X</td> <td style="width: 20px; height: 20px; text-align: center;">X</td> <td style="width: 20px; height: 20px; text-align: center;">-</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> Social Security Number (last 4 digits)	X	X	X	-	X	X	-				
X	X	X	-	X	X	-						
Applying for Entrance in 20_____												
I hereby voluntarily waive and relinquish any right of access to this confidential letter of evaluation. _____ Signature Date	I retain my right of access to this letter of evaluation. _____ Signature Date											

Section Two: To be completed by current Nursing Supervisor.

Instructions: The applicant's current Nursing Supervisor is asked to complete the remainder of this form. Evaluations from friends or family members will not be considered. The Nursing Supervisor's evaluation of the applicant should be based on direct observations and knowledge of the applicant.

Hospital / Medical Center where employed: _____

City _____ State _____ Employment dates: Start (___/___/___) Stop (___/___/___)

Primary Unit : _____ # of beds _____ Average hours worked per week: _____

Secondary Unit (if any): _____ # of beds _____ Average hours worked per week: _____

A. Familiarity with Applicant

1. How do you know the applicant? How well do you know the applicant?

2. How long have you known the applicant? _____

B. If you have reviewed the applicant's academic record, do you believe it is indicative of his/her intellectual ability? If you answer no, please explain.

_____ Yes _____ No _____ Have not reviewed academic records

C. Applicant's Personal Attributes

Please evaluate the applicant in each of the following categories by checking the appropriate column.

Personal Attributes	Excellent (Upper 10%)	Above Average (Upper 33%)	Average (Middle 33%)	Below Average (Lower 33%)	Needs Improvement (Lower 10%)	Not Known
Integrity						
Emotional Maturity						
Motivation						
Social Values						
Intellectual Ability						
Quality Of Expression						
Ability To Organize						
Rapport With Others						
Leadership Qualities						

D. Applicant's Clinical Experience

Please evaluate the applicant with respect to the following clinical procedures and skills by checking the appropriate column. The Admissions Committee is seeking information about the applicant regarding their critical care nursing experience, and the level of competence that they possess. It is not expected that applicants will possess, or be an expert in, every procedure or skill listed below.

Nursing Procedures / Skills	Frequency of Experience				Level of Competence			
	Daily	Weekly	Monthly	Rarely/ Never	Expert	Competent	Novice	Not Known
Arterial pressure monitoring (e.g. radial)								
Venous pressure monitoring (e.g. CVP)								
Pulmonary artery pressure monitoring								
Invasive cardiac output/index determination								
Intracranial pressure monitoring								
IV administration / titration of vasoactive and inotropic agents								
Function as Code Blue Team leader								
Function as Code Blue Team member								
Emergency drug administration								
Fluid resuscitation								
Mechanical ventilation								
Arterial blood gas interpretation								
Basic dysrhythmia interpretation								
12-lead ECG interpretation								
Temporary transvenous/epicardial pacemaker								
Cardioversion / Defibrillation								
Transcutaneous (e.g. external) pacemaker								
IV antidysrhythmic agents								
IV thrombolytic agents								
Chest tubes (e.g. mediastinal, pleural)								
Extracorporeal membrane oxygenation								
Intra-aortic balloon pump								
Ventricular assist device								
Hemofiltration/dialysis (e.g. CA-VHD, CV-VHD)								

E. Narrative Comments

Please provide any additional information that you feel would be of value to the Admissions Committee in considering this applicant. This section is valuable in making decisions where all else appears equal. Additional comments are invited, however they must be provided on official business letterhead and bear the author's signature.

F. Overall Recommendation

Considering all the applicants to nurse anesthesia programs that you have known, please check the box indicating the category in which you would place this applicant.

- Recommend enthusiastically – upper 10 percent of applicants
- Recommend with confidence – upper one-third of applicants
- Recommend – middle one-third of applicants
- Recommend with reservation – lower one-third of applicants
- Do not recommend (please explain above under *Narrative Comments.*)

G. Evaluator's Information: (please type or print)

Nursing Supervisor's Name: _____

Title: _____

Mailing address: _____

City/State: _____, _____ Zip _____

Phone: (_____) _____ - _____

Nursing Supervisor's Signature _____ Date _____

Please return this evaluation, in an official business envelope, directly to:

Office of Graduate Studies, Florida Gulf Coast University, 10501 FGCU Blvd. S., Fort Myers, FL 33965.

DO NOT RETURN COMPLETED EVALUATION FORM TO THE APPLICANT.

