

MONTANA STATE BOARD OF NURSING

DEPARTMENT OF LABOR & INDUSTRY
 301 S PARK PO BOX 200513 HELENA MT 59620-0513
 FAX (406) 841-2238 PHONE (406) 841-2344

COUNSELOR EVALUATION REPORT Reporting Period: _____ to _____

Probationer's Name (print legibly please): _____ License #: _____

Name of Counselor: _____ Phone #: _____ Fax #: _____

Counselor's Address: _____
Street or PO Box City Zip

Counselor's Credentials: _____ Counselor's License #: _____

Date of Last Session: _____ Frequency of Sessions: _____

Have you read the Final Order and/or Stipulation Entered Into by the Probationer and the Board? ____ Yes ____ No

Ratings: 1 = poor 2 = fair 3 = average 4 = above average 5 = excellent
(Any ratings below 3 must be thoroughly explained.)

Treatment/Therapeutic Goals and Specific Behavioral Issues	Rating	Comments
Problem: Goals:	1 2 3 4 5	
Problem: Goals:	1 2 3 4 5	
Problem: Goals:	1 2 3 4 5	
Number of sessions probationer has cancelled or called in sick	# _____	
Reliability in reporting to sessions as scheduled	1 2 3 4 5	
Compliance with treatment plan	1 2 3 4 5	
Communication skills	1 2 3 4 5	
Attitude and behavior towards others	1 2 3 4 5	

List this probationer's strengths at this point: _____

List any additional concerns at this point: _____

Signature of Evaluator: _____ Date: _____

*** Important Note:** Counselor evaluation reports must be submitted to the Board to ensure Licensee's compliance with the conditions of licensee's probation. Any reports submitted beyond the due date may have a negative impact on the probationer's license as late reports constitute a violation of the final order of the board.