ARKANSAS STATE BOARD OF NURSING
DEPARTMENT OF ENFORCEMENT

Licensee: _____ License No.: _____

Facility: _____ Location: _____

Direct Supervisor (including title): _____

Supervisor Email: _____ Supervisor Phone: _____

MONITORED NURSE EMPLOYER ACKNOWLEDGEMENT

Please read carefully and initial each item acknowledging the following:

___ 1. I acknowledge that the above-named licensee has provided a copy of their Consent Agreement or Board Order and I have reviewed it.

___ 2. As the employer, I will submit a *'Performance Evaluation Report'* every three (3) months directly to the Arkansas State Board of Nursing (ASBN) on behalf of the above-named licensee. The licensee is responsible for obtaining the required form to be submitted and providing the applicable due dates.

I acknowledge that I have read and understand the above requirements.

_____ _____
(Employer Signature) (Date)

_____ _____
(Licensee Signature) (Date)

Created: July 2019
Revised: May 2020
Located: Discipline\FORMS2