PEER ASSISTANCE PROGRAM OKLAHOMA BOARD OF NURSING
P.O. Box 52926 405/525-2277
Oklahoma City, OK 73152 Fax 405/525-0350

Change of Supervisor Form

_____
Date (Circle One): Temporary Permanent

PLEASE PRINT THE FOLLOWING INFORMATION:

_____
Name of Nurse Participant:

_____
Name and address of Employer

_____
Phone number and extension

_____
New Supervising Nurse (Name, Title and License #)

_____
Name of Supervising Nurse being replaced

Reason for the Change:

_____

Effective Date:

[T**he new supervising nurse, the nurse manager and the nurse participant must all sign this form**.]

I have reviewed the existing Peer Assistance Program Contract and the Supervised Practice Agreement for the above named Program participant and agree to assist this individual according to the terms of the contract and agreement.

_____ _____
Signature of New Supervising Nurse Date

_____ _____
Signature of Nurse Manager Date

I am aware of the change in my supervising nurse(s) effective _____(date).

_____ _____
Signature of Nurse Participant Date