



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
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**SUPERVISOR VERIFICATION AND AGREEMENT TO MONITOR PRACTICE AND
PROVIDE PERIODIC REPORTS TO THE BOARD OF REGISTRATION IN NURSING**

Date: _____

Dear Massachusetts Board of Registration in Nursing:

This is to confirm that Name and License No.: _____ has informed me that he/she is a participant in the Board of Registration in Nursing (Board) Substance Addiction Recovery Program (SARP), and has provided me with a copy of his/her current SARP Consent Agreement for SARP Participation (CASP), as well as the "CASP Amendment" outlining all required practice conditions.

I understand I am agreeing to:

- submit to the SARP, as required, a Nursing Supervisor Report of the nurse;
- ensure compliance with the practice restrictions of the nurse as detailed in the SARP Participation Agreement and CASP Amendment; and
- immediately report any violations to SARP at **(617)973-0904** of restricted practice requirements or any other concerns with the nurse's practice

I understand the nurse's CASP compliance is monitored by the SARP Program that the nurse may be temporarily removed from practice for instances of noncompliance.

I understand the goal of SARP is to provide the nurse with an opportunity to engage in sustained recovery while demonstrating safe nursing practice.

I further certify that I am a **RN / LPN (circle one)**, have completed at least one (1) year of clinical nursing practice, and that I do not have any open administrative or criminal complaint, or any current license discipline by any Board of Nursing.

Supervisor Name and License No.

Job Title of Supervisor

Supervisor Signature and Date

Facility Name

Address

City

State

Zip

Telephone Number