The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

KATHLEEN E. WALSH
Secretary

ROBERT GOLDSTEIN, MD, PhD
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

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)_____**, 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 Signature Date

_____
Facility Name

_____
Address

_____
City State Zip Telephone Number