Commonwealth of Massachusetts
Department of Public Health
Bureau of Health Professions Licensure
Board of Registration in Nursing
250 Washington Street
Boston, Massachusetts 02108

SUPERVISOR VERIFICATION, AND AGREEMENT TO MONITOR APRN PRACTICE AND PROVIDE PERIODIC REPORTS TO THE BOARD OF REGISTRATION IN NURSING

Name of APRN on Probation _____

License No. _____Docket No(s). _____

APRN's Date of Employment: _____ APRN's Job Title: _____

Employer Name and Address: _____

_____

I, _____ (print supervisor's full name) on _____(insert date) reviewed a signed copy of the Probation Agreement (Agreement) or Order between _____ (insert APRN's name) and the Board of Registration in Nursing (Board). I hereby agree that I will monitor and evaluate this APRN's practice as specified in the Agreement or Order, and will provide written reports to the Board on the Supervision Report form provided by the Board at the intervals required by the Agreement or Order.

I also agree to promptly notify the Board's Probation Compliance Officer if the APRN resigns or is terminated from employment.

I further certify that I am one of the following (please check)

____ a CNP/CNM/CRNA/PNMHCS/CNS (circle one) with a license and ARPN authorization issued by the Board that is current ad in good standing

____ a MD with a license issued by the Board of Registration in Medicine that is current and in good standing.

SUPERVISOR'S SIGNATURE_____Date:_____

_____

(Print/Type: Name and Title of Supervisor completing this form)

Supervisor's License Type and No.:_____ Supervisor Phone No.:_____

PLEASE NOTE CAREFULLY: **This completed form must be mailed *with* the supervisor's signed cover letter written on the facility's letterhead directly to: Probation Compliance Officer DPH – BHPL, Board of Registration in Nursing**

FORM 1A- Manual Version
Adopted 11/6/16
Revised 8/14/017, 05/09/18, 06/21/21

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