



MONITORED NURSE EMPLOYER ACKNOWLEDGEMENT

Licensee _____ License number _____

Facility _____ Location _____

Direct Supervisor (including title) _____

Supervisor email _____ Supervisor phone _____

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 provide a 'Performance Evaluation Report' every three (3) months to the licensee to upload or submit directly to the Arkansas State Board of Nursing (ASBN) at ASBN.monitoring@arkansas.gov on behalf of the 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

Instructions for licensee if form given to you by employer:

- **Licensee with Affinity drug monitoring** – upload signed document in your Affinity account under Documentation Reports/Available Reports/Add Attachment
- **Licensee without drug monitoring** – please email to ASBN.monitoring@arkansas.gov