

PEER ASSISTANCE PROGRAM

2901 N. Classen Blvd., Suite 101
Oklahoma City, OK 73106

OKLAHOMA BOARD OF NURSING

405/525-2277
Fax 405/525-0350

Change of Supervisor Form

Date

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: _____

[The 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