502-429-3300 800-305-2042 Fax: 502-429-1245



Employer Verification Form

Participant Name							
	KARE for Probation	RE for Nurses Program pation					
Purpose:		To verify the employers' knowledge of the provisions contained in the KARE for Nurses Program Agreement dated					
Directions:		When employed as a nurse, each employer shall complete and return this form directly to the Kentucky Board of Nursing Compliance Branch, following discussion of the provisions with the participant as well as his/her Compliance Nurse Investigator.					
Partici	pant K	entucky Board of Nu	rsing L	icense Numb	oer:		
I certify	/ that th	e above named partic	ipant, _				
was employed h		by this facility on	(month/date/year) as a (employment position)				
			(11101111	ruate/year)		(employment position)	
(Print) Director of Nursing		r of Nursing		(Signature) [Director o	f Nursing	
(Print) Immediate Supervisor			(Signature) Immediate Supervisor				
		Name of Facility:					
		Address:					
		Telephone Number:					
			Date:				

RETURN THIS FORM TO THE KBN COMPLIANCE BRANCH