Treating Practitioner Verification Form

Patient/Participant Name ________________________________

☐ KARE for Nurses Program
☐ Probation

Purpose: To verify the treating practitioner(s) knowledge of the provisions contained in the KARE for Nurses Program Agreement dated ________________ or Agreed Order/Board Decision entered on ________________.

Directions: Please complete and return this form directly to the Kentucky Board of Nursing Compliance Section, Consumer Protection Branch, following discussion of the terms with the participant.

Participant Kentucky Board of Nursing License Number: __________________________

Treating Practitioner Name (Print) ___________________________ Treating Practitioner Signature ___________________________

Name of Facility: __________________________
Address: __________________________
_________________________________________
Telephone Number: __________________________
E-mail address: __________________________
Date: ___________________________________

RETURN THIS FORM TO COMPLIANCE SECTION, CONSUMER PROTECTION BRANCH

jmc