Oregon State Board of Nursing
800 NE Oregon Street, Suite 465, Portland, OR 97232-2162
Phone: 971-673-0685 • **Fax:** 971-673-0684 • **License Verification:** 971-673-0679
E-mail: oregon.bn.info@state.or.us • **Website:** www.oregon.gov/OSBN
Nurse Monitoring Program: 971-673-0655

Terms and Conditions for Nursing Practice During Participation in the Nurse Monitoring Program

Employer

As the supervisor of ___________________________, who is a participant in the Nurse Monitoring Program, I verify the following conditions of her/his supervision.

- I confirm that ___________________________ has informed me of her/his participation in the Nurse Monitoring Program.
- I agree to schedule her/his to work as follows:
  - He/She may work up to 40 hours per week. May only work in one setting.
  - He/She may occasionally work overtime hours to finish a shift.
  - He/She may NOT have access to Narcotics and Controlled Substances in the workplace.
- I will immediately notify the Nurse Monitoring Program of any concern regarding ________________________'s nursing practice, behavior or conduct.
- I will submit written reports on forms provided by the Nurse Monitoring Program every quarter beginning August 1, 2005.
- I will remove ________________________ from the work setting if there are signs of relapse or relapse behavior. Practice will resume only after discussion with the NMP coordinator and me.
- I understand that the Nurse Monitoring Program will communicate to me any concerns regarding her/his lack of compliance with the terms and conditions of the nursing practice agreement.
- I understand that this contract will be reviewed one year from the date of signing and revisions will occur as agreed upon by the Nurse Monitoring Program, my employee, and me.
- I confirm that I will keep the terms and conditions of this contract and _________ ______'s participation in the Nurse Monitoring Program confidential. I will limit the persons who know of her/his status to those individuals who need to know in order to assure that the terms and conditions of this contract are met.

_________________________________ _____________________________

Employer Signature Date

_________________________________ _____________________________

Coordinator, Nurse Monitoring Program Date

Please Sign And Return To The Nurse Monitoring Program

SAMPLE