

LOUISIANA STATE BOARD OF PRACTICAL NURSE EXAMINERS  
131 AIRLINE DRIVE, SUITE 301  
METAIRIE, LOUISIANA 70001-6266  
(504) 838-5791  
Fax: (504) 838-5279  
www.lsbpne.com

**EMPLOYER'S AGREEMENT**

**This form must be completed by the on-site supervisor who is directly responsible for monitoring everyday nursing duties of the LPN:**  
(Please **print** or **type** the information requested in the space provided below)  
**Please attach a copy of the LPN's job description**

**Directions:** Employer(s) must review this individual's board order/consent order to include the findings of fact and conclusions of law prior to the individual beginning or returning to work (including orientation) and prior to completing this form, as applicable: **1) Employees with continuous employment (current employee who has retained employment and now has a board order):** Mail this agreement to the board office within **ten (10) calendar days** of this individual returning to work; **2) Employee obtaining new employment:** mail this agreement to the board office within **ten (10) calendar days** of this individual beginning work/orientation.

Name of LPN: \_\_\_\_\_ LPN license Number: \_\_\_\_\_

Position of LPN: \_\_\_\_\_ Shift: \_\_\_\_\_  
(7-3, 3-11, 11-7, etc.)

Unit/Department: \_\_\_\_\_ Start date: \_\_\_\_\_  
(including orientation)

Name of facility: \_\_\_\_\_

Address of facility: \_\_\_\_\_  
\_\_\_\_\_

Telephone number: \_\_\_\_\_ Facsimile number: \_\_\_\_\_

Name of **on-site** supervisor: \_\_\_\_\_ Supervisor shift: \_\_\_\_\_  
(Party authorized to complete **Performance Evaluation**) (Print name) (7-3, 3-11, 11-7, etc.)

Telephone number: \_\_\_\_\_ Facsimile number: \_\_\_\_\_  
(Party authorized to complete **Performance Evaluation**)

E-mail address: \_\_\_\_\_  
(Party authorized to complete **Performance Evaluation**)

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The above named licensed practical nurse has been ordered or has agreed to work with restrictions in the health care setting. Special monitoring procedures are required to facilitate safe practice and public safety. It is essential that the employer participate in this part of the monitoring requirements. The employee should have given you a copy of their board order including all findings of fact and conclusions of law before returning to or beginning employment with you.

The following items are requested of the employer:

1. The individual must be **directly supervised** by an **on-site** RN/LPN/Physician. Note, if monitored by another LPN, that person must be higher on the organizational chart than the individual being monitored.
2. The **on-site** supervisor will submit a written report of the individual's job performance each month, bi-monthly, or quarterly, depending upon the specified stipulations in the order. This report must be submitted to the board by the **on-site supervisor**.
3. Notify the board in writing if there is a change in the **on-site** supervisor.
4. Immediately notify the board of any adverse reports, performance issues, or any other violations of the Nurse Practice Act, including but not limited to termination/resignation/separation.
5. Additional terms may be specified in the order.

**I have received and reviewed the board order/consent order including findings of fact and conclusions of law.**

\_\_\_\_\_  
Director of Nursing

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Direct on-site Supervisor\*

(Party authorized to complete **Performance Evaluation**)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Nurse/applicant

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
Executive Director

\_\_\_\_\_  
(Date)

**"Supervision"** means that the supervisor (LPN, RN, or physician) has regular and consistent opportunities to evaluate the performance of the respondent.

\*Nurses must have **on-site supervision** during the entire term of the program agreement or until completion of probation. The on-site supervisor must read the board order/consent order, must see the nurse regularly during the scheduled shift and must know the participant well enough to recognize any changes.

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**BOARD ORDER/CONSENT ORDER ACKNOWLEDGMENT FORM**

(To be completed and submitted by employer/assessor)

Date \_\_\_\_\_

RE: \_\_\_\_\_, LPN / applicant for licensure

I \_\_\_\_\_, hereby acknowledge receipt and  
(Please Print)

review of the above named licensed practical nurse / applicant's board order/consent order, including findings of facts and conclusions of law.

Print name of supervisor/assessor \_\_\_\_\_

Signature of supervisor/assessor \_\_\_\_\_

Name of facility \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_

*Instructions:*

*Employer – submit the form directly to the board office along with the Letter of Hire.*

*Assessor (psychiatrist/psychologist/addictionologist) – submit the form directly to the board office along with the entire assessment and treatment recommendations.*

Revised 11/2013