MnVP Employer Acknowledgement Form

Mississippi Nurse Voluntary Program (MnVP)

_____

Agency Name Address Phone Number

This organization is aware of _____, being a participant in MnVP.
(Print full name of employee)

A copy of the MnVP Monitoring Agreement has been received and our organization agrees to employ the participant according to the terms and conditions of the Agreement. In accordance with the Mississippi Administrative Code, Part 2826, Rule 1.7, MnVP participants have agreed to the following: (1) Notify and obtain approval from MnVP of any health care related position or job change prior to making the change or relocating (2) Abide by return-to-work restrictions and requirements (3) Abide by all policies, procedures and contracts of the employer (4) Inform all employers or schools of participation in MnVP and provide a copy of the contract, stipulations or final orders from MSBN to any prospective or current nursing position employers and ensure written verification is received by MnVP of said notification (5) Ensure the supervisor at the place of employment is given a copy of the MnVP contract and any necessary forms (6) Ensure MnVP receives the MnVP employer notification form signed by the direct supervisor at the place of employment prior to beginning a new or resuming an existing position (7) Notify MnVP within forty-eight (48) hours of any change in supervisor or employment. MnVP participants also have agreed, if employed in the nursing field, in a position that requires utilization of a nursing license, or in a healthcare related field, the participant is required to have that employer submit a quarterly report that covers the time during the quarter the participant was employed with that employer – regardless of the length of time employed or whether employment was full-time, part-time, PRN or volunteer status.

As Employer, I acknowledge as a third party identified above, I have authorization to communicate with a representative from MnVP to discuss any compliance or non-compliance with the terms and conditions of Employee's participation within MnVP.

_____

Worksite Monitor Name/License# Position Title Contact Information

MnVP Monitoring Agreement was provided by nurse: Yes _____ No _____
Select Type of Employment: Full-Time ____ Part-Time ____ PRN ____ Volunteer____
Employee Position Title: _____ Department/Unit _____
Start Date: _____ Are controlled substances administered at this facility?
MM/DD/YYYY Yes ____ No ____. **If yes, submit a copy of your controlled substance administration and waste policies.**

This form must be submitted to/received by MnVP **PRIOR** to the participant beginning a new or resuming an existing position. **PLEASE NOTE THAT THE NURSE MAY NOT START UNTIL THE AGENCY HAS RECEIVED A COMPLETED COPY FROM MnVP APPROVING THE NURSE TO WORK AT THIS AGENCY**. In conjunction to this form, an MnVP Initial Employer Report is due to MnVP within 10 days of the participant's start date. Afterwards, an MnVP Employer Report is due to MnVP quarterly: April 15th, July 15th, October 15th and January 15th.

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Direct Supervisor Printed Name Signature Date

Please mail, email and/or fax this completed form along with applicable requested documentation to: **Attention MnVP**.

For MnVP Use Only:
Worksite: Approved _____ Not Approved: _____
If not approved, provide reason:_____
Is this nurse under a narcotics restriction? Yes _____ No _____
(Please note that all participants will have a letter when his/her restriction is lifted)

MnVP Staff Signature: _____ Date: _____

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