## Mississippi Nurse

713 Pear Orchard Road Plaza II, Suite 300 Ridgeland, MS 39157 (601)957.6298-Casey (601)957.6266 - Sheron (601)957.6301-Fax MnVP@msbn.ms.gov

## **MnVP Employer Acknowledgement Form**

the participant according to the terms and conditions of the Agreement. In accordance with the Wississippi 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 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 a prospective or current nursing position employers and ensure written verification is received by MnV fisal notification (5) Ensure the supervisor at the place of employment is given a copy of the MnV 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 equires 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 we are representative from MnVP to discuss any compliance or non-compliance with the terms and conditions of Employeres participation within MnVP.  Morksite Monitor Name/License# Position Title Contact Information  MnVP Monitoring Agreement was provided by nurse: Yes No Figes, submit a copy of your controlled substances administered at this facility?  MM/DD/YYYY Yes No If ye	(Print full name of employee) Ac opy of the MnVP Monitoring Agreement has been received and our organization agrees to employ he participant according to the terms and conditions of the Agreement. In accordance with the Mississipi 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 haking the change or relocating (2) Abide by return-to-work restrictions and requirements (3) Abide by II policies, procedures and contracts of the employer (4) Inform all employers or schools of articipation in MnVP and provide a copy of the contract, stipulations or final orders from MSBN to any rospective 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 ontract and any necessary forms (6) Ensure MnVP receives the MnVP employer notification form gined by the direct supervisor at the place of employment prior to beginning a new or resuming gined by the direct supervisor at the place of employment prior to beginning a new or resuming gined by the direct supervisor at the place of employment prior to beginning a new or resuming gined by the direct supervisor at the place of employment prior to beginning a new or resuming gined by the direct supervisor or mployment. MnVP participants also have agreed, if employed in the nursing filed, in a position that equires utilization of a nursing license, or in a healthcare related field, the participant is required to ave 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.  Se Employer, I acknowledge as a third party identified above, I have authorization to communicate with representative from MnVP to discuss any compliance or non	Agency Name	Address		Priorie Number
the participant according to the terms and conditions of the Agreement. In accordance with the Mississispip 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 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 a prospective or current nursing position employers and ensure written verification is received by MnV footract and any necessary forms (6) Ensure MnVP receives the MnVP employer notification form signed by the direct 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 equires utilization of a nursing license, or in a healthcare related field, the participant is required to nave 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 we are representative from MnVP to discuss any compliance or non-compliance with the terms and conditions of Employers's participation within MnVP.  Morksite Monitor Name/License# Position Title Contact Information  MnVP Monitoring Agreement was provided by nurse; Yes No Feet PRN Volunteer	ne participant according to the terms and conditions of the Agreement. In accordance with the fississispip Administrative Code, Part 2826, Rule 1.7, MnVP participants have agreed to the following: its Notify and obtain approval from MnVP of any health care related position or job change prior to naking the change or relocating (2) Abide by return-to-work restrictions and requirements (3) Abide by Il policies, procedures and contracts of the employer (4) Inform all employers or schools of articipation in MnVP and provide a copy of the contract, stipulations or final orders from MSBN to any rospective or current nursing position employers and ensure written verification is received by 5 fail notification (5) Ensure the supervisor at the place of employment is given a copy of the MnVP ontract and any necessary forms (6) Ensure MnVP receives the MnVP employer notification form igned by the direct supervisor at the place of employment is given a copy of the MnVP ontract and any necessary forms (6) Ensure MnVP receives the MnVP employer notification form igned by the direct supervisor at the place of employment prior to beginning a new or resuming an xisting position (7) Notify MnVP within forty-eight (48) hours of any change in supervisor or mployment. MnVP participants also have agreed, if employed in the nursing field, in a position that equires utilization of a nursing license, or in a healthcare related field, the participant is required to ave that employer submit a quarterly report that covers the time during the quarter the participant was full-time, part-time, PRN or volunteer status.  In Employer, I acknowledge as a third party identified above, I have authorization to communicate with representative from MnVP to discuss any compliance or non-compliance with the terms and onditions of Employee's participation within MnVP.  Morksite Monitor Name/License# Position Title Contact Information  MnVP Monitoring Agreement was provided by nurse: Yes No PROME AND ADMINISTRY United The Section Title Section Title Sect	This organization is aware of			being a participant in MnVP.
MnVP Monitoring Agreement was provided by nurse: Yes No Select Type of Employment: Full-Time Part-Time PRN Volunteer Select Type of Employment: Full-Time Part-Time PRN Volunteer Select Type of Employment: Full-Time Part-Time PRN Volunteer Select Type of Employment: Full-Time PRN Volunteer PRN PRN Volunteer PRN Volunteer PRN PRN Volunteer PRN Volunteer PRN Volunteer PRN Volunteer PRN PRN Volunteer PRN PRN Volunteer PRN Volunteer PRN PRN Volunteer PRN PRN Volunteer PRN	MnVP Monitoring Agreement was provided by nurse: Yes No Volunteer part-Time PRN Volunteer part-Time PRN Volunteer pepartment/Unit Are controlled substances administered at this facility?	the participant according to the Mississippi Administrative Code 1) Notify and obtain approval making the change or relocating the change or relocating policies, procedures and contract and in MnVP and proportions are all notification (5) Ensure the contract and any necessary for signed by the direct supervisor existing position (7) Notify MnN employment. MnVP participant requires utilization of a nursing nave that employer submit a contract and any necessary for existing position (7) Notify MnN employment. MnVP participant requires utilization of a nursing nave that employer submit a contract and signed with that employers as full-time, part-time, PRN of the Employer, I acknowledge as a representative from MnVP to	le terms and condite, Part 2826, Rule from MnVP of arming (2) Abide by rentracts of the emvide a copy of the gposition employ the supervisor at trms (6) Ensure Mar at the place of every within forty-eights also have agregalicense, or in a liquarterly report the place of the company of the supervisor at the place of every within forty-eights also have agregalicense, or in a liquarterly report the company of t	ditions of the Agreer e 1.7, MnVP participally health care relate eturn-to-work restrict ployer (4) Inform all econtract, stipulationers and ensure writt the place of employnVP receives the Mremployment prior to ght (48) hours of anyted, if employed in the lealthcare related finat covers the time of the length of times.	ment. In accordance with the ants have agreed to the following: d position or job change prior to tions and requirements (3) Abide by employers or schools of ns or final orders from MSBN to any ten verification is received by MnVP employer notification form to beginning a new or resuming any change in supervisor or the nursing field, in a position that teld, the participant is required to during the quarter the participant to employed or whether employments authorization to communicate with
MnVP Monitoring Agreement was provided by nurse: Yes No Select Type of Employment: Full-Time Part-Time PRN Volunteer Select Type of Employment: Full-Time Part-Time PRN Volunteer Select Type of Employment: Full-Time Part-Time PRN Volunteer Select Type of Employment: Full-Time PRN Volunteer PRN PRN Volunteer PRN Volunteer PRN PRN Volunteer PRN PRN Volunteer PRN PRN Volunteer PRN	MnVP Monitoring Agreement was provided by nurse: Yes No Volunteer part-Time PRN Volunteer part-Time PRN Volunteer pepartment/Unit Are controlled substances administered at this facility?				
Select Type of Employment: Full-Time Part-Time PRN Volunteer Employee Position Title: 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 AGENCE 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 the participant's start date. Afterwards, an MnVP Employer Report is due to MnVP quarterly: April 15th, October 15th and January 15th.  Direct Supervisor Printed Name Signature Date  Please mail, email and/or fax this completed form along with applicable requested documentation to actention MnVP.  For MnVP Use Only:  Worksite: Approved Not Approved:  If not approved, provide reason:  Is this nurse under a narcotics restriction? Yes No	elect Type of Employment: Full-Time Part-Time PRN Volunteer mployee Position Title: 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.  his form must be submitted to/received by MnVP PRIOR to the participant beginning a new or esuming an existing position. PLEASE NOTE THAT THE NURSE MAY NOT START UNTIL THE AGENCY IAS RECEIVED A COMPLETED COPY FROM MnVP APPROVING THE NURSE TO WORK AT THIS INCENCY. 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.  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: f not approved, provide reason: s this nurse under a narcotics restriction? Yes No (Please note that all participants will have a letter when his/her restriction is lifted)	Norksite Mo <mark>nit</mark> or N <mark>ame/Licen</mark> :	se# Posi	tion Title	Contact Information
AGENCY. In conjunction to this form, an MnVP Initial Employer Report is due to MnVP within 10 days the participant's start date. Afterwards, an MnVP Employer Report is due to MnVP quarterly: April 15 duly 15th, October 15th and January 15th.  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: No No Is this nurse under a narcotics restriction? Yes No No Is this nurse under a narcotics restriction? Yes No No In No In In No No In No In No In No In No In No No In No No No In No No In No No No In No	As 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.  Direct Supervisor Printed Name  Signature  Date  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: f not approved, provide reason: s this nurse under a narcotics restriction? Yes No Please note that all participants will have a letter when his/her restriction is lifted)	Select Type of Employment: Formula For	ull-Time Are controlled su Yes No	Part-Time Depart ubstances administe . <b>If yes, submit a co</b>	PRN Volunteer ment/Unit ered at this facility? ppy of your controlled
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 mail, email and/or fax this completed form along with applicable requested documentation to:  Attention MnVP.  For MnVP Use Only:  Worksite: Approved Not Approved: f not approved, provide reason: s this nurse under a narcotics restriction? Yes No Please note that all participants will have a letter when his/her restriction is lifted)	esuming an existin <mark>g position.</mark> HAS RECEIVED A COMPLETED  AGENCY. In conjunction to this  the participant's start date. Aft	PLEASE NOTE TO COPY FROM Mr s form, an MnVP terwards, an MnV	HAT THE NURSE MA NVP APPROVING TH Initial Employer Rep	AY NOT START UNTIL THE AGENCY IE NURSE TO WORK AT THIS Nort is due to MnVP within 10 days o
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 mail, email and/or fax this completed form along with applicable requested documentation to:  Attention MnVP.  For MnVP Use Only:  Worksite: Approved Not Approved: f not approved, provide reason: s this nurse under a narcotics restriction? Yes No Please note that all participants will have a letter when his/her restriction is lifted)				
For MnVP Use Only:  Worksite: Approved Not Approved:  If not approved, provide reason:  Is this nurse under a narcotics restriction? Yes No	For MnVP Use Only:  Worksite: Approved Not Approved: f not approved, provide reason: s this nurse under a narcotics restriction? Yes No  Please note that all participants will have a letter when his/her restriction is lifted)	Direct Supervisor Printed Nam	ie	Signature	Date
Worksite: Approved Not Approved: If not approved, provide reason: Is this nurse under a narcotics restriction? Yes No	Worksite: Approved Not Approved: f not approved, provide reason: s this nurse under a narcotics restriction? Yes No Please note that all participants will have a letter when his/her restriction is lifted)		his completed fo	rm along with applic	cable requested documentation to:
	Please note that all participants will have a letter when his/her restriction is lifted)	Worksite: Approved If not approved, provide rea	son:		
(Please note that all narticinants will have a letter when his/her restriction is lifted)					
(i tease note that all participants will have a tetter when his/her restriction is tirted)	MnVP Staff Signature: Date:	(Please note that all particip	ants will have a	letter when his/he	r restriction is lifted)
MnVP Staff Signature: Date:		MnVP Staff Signature:			Date: