

MnVP Quarterly Self-Report

Participant's Name: _____

Report for (circle one):

Jan-Mar Apr-Jun Jul-Sept Oct-Dec Year: 20_____

Practice :

I have *(Select the appropriate statement below)*

___ NOT been working at all during this quarter

___ NOT been working in the field of nursing or healthcare related field during this quarter

___ been working in the field of nursing or healthcare related field during this quarter

Employer Name: _____

Employer Address: _____

Worksite Monitor Name & Contact: _____

Select Type of Employment: Full-Time ___ Part-Time ___ PRN ___ Volunteer ___

Position Title: _____ Department _____ Start

Date: _____ End Date (if applicable): _____

If applicable, provide a brief explanation surrounding the reason no longer employed (terminated, resigned, other) _____

Was separation of employment reported to MnVP? Yes ___ No ___

Method of communication used to report to MnVP? Call ___ Personal email ___ Affinity ___ Other ___, if other selected, describe _____

_____ MnVP staff reported to? _____

Health: Describe any health problems and/or treatments.

Copies of prescriptions or documentation of any treatment, hospitalization, office visit, etc. must be enclosed or forwarded to MnVP. Describe any upcoming medical or dental procedures that are currently scheduled for next quarter.

Recovery:

Share insights, Problems, 12 Step Work, Progress with Sponsor, Growth during the past month:

Please submit report directly to MnVP via Spectrum/Affinity

Mississippi Nurse Voluntary Program (MnVP)

713 S. Pear Orchard Road
Plaza II, Suite 300
Ridgeland, MS 39157
(601)957.6300-Office
(601)957.6301
MNVP@msbn.ms.gov

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Participant's Name: _____

Report for (circle one):

Jan-Mar Apr-Jun Jul-Sept Oct-Dec Year: 20_____

By signing this form, I, _____, acknowledge my responsibility to do the following according to the Mississippi Administrative Code, Part 2826: (1) Maintain continuous employment as provided in the MnVP contract to be eligible for successful discharge from MnVP. (2) Notify and obtain approval from MnVP of any health care related position or job change prior to making the change or relocating (3) Abide by return-to-work restrictions and requirements (4) Abide by all policies, procedures and contracts of the employer (5) 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 (6) Ensure the supervisor at the place of employment is given a copy of the MnVP contract and any necessary forms (7) 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 (8) Notify MnVP within forty-eight (48) hours of any change in supervisor or employment. I also understand if I am employed in the nursing field, in a position that requires me to be a licensed nurse, or in a healthcare related field, I am required to have that employer submit a quarterly report that covers the time during the quarter I was employed with that employer – regardless of the length of time employed or whether employment was full-time, part-time, PRN or volunteer status.

Participant's Signature

Date

Please submit report directly to MnVP via Spectrum/Affinity

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