502-429-3300
800-305-2042
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KENTUCKY BOARD OF NURSING

312 Whittington Parkway, Suite 300
Louisville, Kentucky 40222-5172
kbn.ky.gov

Andy Beshear
Governor

Employer Verification Form

Participant Name _____

☐ KARE for Nurses Program
☐ Probation

Purpose: To verify the employers' knowledge of the provisions contained in the KARE for Nurses Program Agreement dated _____
or
Agreed Order/Board Decision entered on _____.

Directions: When employed as a nurse, each employer shall complete and return this form directly to the Kentucky Board of Nursing Compliance Branch, following discussion of the provisions with the participant as well as his/her Compliance Nurse Investigator.

Participant Kentucky Board of Nursing License Number: _____

I certify that the above named participant, _____,

was employed by this facility on _____ as a _____.
(month/date/year) (employment position)

_____ _____
(Print) Director of Nursing (Signature) Director of Nursing

_____ _____
(Print) Immediate Supervisor (Signature) Immediate Supervisor

Name of Facility: _____

Address: _____

_____

Telephone Number: _____

E-mail address: _____

Date: _____

RETURN THIS FORM TO THE KBN COMPLIANCE BRANCH

8/21/2006; 10/28/2013; 6/30/2014; 2/10/2015; 12/9/2015
jmc
3/17/2022
bks