Nebraska Department of Health & Human Services
Division of Public Health
Licensure Unit, PO Box 94986
Lincoln NE 68509-4986
(402) 471-2666 Fax (402)742-2360

ATTESTATION of SUPERVISON

Nurse Practitioner Name _____ Phone (H)_____ (W)_____

Address _____ Nurse Practitioner License # _____

_____ Specialty _____

Supervising Provider Name _____ Phone _____

Address _____ License Type and # _____

_____ Specialty _____

The above named parties have developed a formal, written transition-to-practice agreement and agree to the following:

1. The Nurse Practitioner and supervising provider shall practice collaboratively within the framework of their respective scopes of practice;
2. The Nurse Practitioner and supervising provider shall each be responsible for his or her individual decisions in managing the health care of patients through consultation, collaboration, and referral;
3. The Nurse Practitioner and supervising provider shall have joint responsibility for the delivery of health care to a patient based upon the scope of practice of each practitioner;
4. The supervising provider shall be responsible for supervision of the Nurse Practitioner to ensure the quality of health care provided to patients;
5. If the transition to practice agreement is terminated prior to the Nurse Practitioner having practiced for 2,000 hours, the supervising provider and the Nurse Practitioner have a duty to notify the Department.

Nurse Practitioner

I_____attest that I am the person referred to in this document as a Nurse Practitioner (NP) in the State of Nebraska; that the statements herein are true to the best of my knowledge and belief; and that I have read and understand the transition to practice agreement.

Signature _____ Date _____
Nurse Practitioner

Supervising Provider

I_____attest that I am the person referred to in this document as the supervising provider and that the statements herein are true to the best of my knowledge and belief; and that I have read and understand the transition to practice agreement. I further attest that I am a Nurse Practitioner who has completed 10,000 hours of practice as a Nurse Practitioner in Nebraska or another jurisdiction, that I am a Nurse Practitioner licensed and practicing in Nebraska, and that I am practicing in the same practice specialty, related specialty or field of practice as the nurse practitioner being supervised.

Signature _____ Date _____
Supervising Provider