

CERTIFIED NURSING ASSISTANT
INITIAL NURSING SUPERVISOR REPORT

This form must be completed by the nursing supervisor for:

NAME OF CNA: _____

Name of Nursing Supervisor: _____

Name of Employer: _____

Address: _____

Phone: _____ E-mail: _____

DESCRIBE THE DUTIES AND RESPONSIBILITIES TO BE CARRIED OUT BY THIS CNA. (Please also attach job description):

SHIFT/HOURS TO BE WORKED PER PAY PERIOD

DATE OF EMPLOYMENT INCLUDING ORIENTATION

NAC 632.048 "Direct Supervision" defined: "Direct Supervision" means the direction given by a supervisor/charge nurse of nurses who is periodically available at the site where care is provided to a patient or available for immediate guidance. **Failure to supervise (NAC 632.890 (7)) is a violation of the Nevada Nurse Practice Act, which is grounds for discipline against the supervisor's license by the Board.**

I acknowledge that I have read the Probationary Agreement for the above name individual and I understand the role of the supervisor.

Signature of Supervisor Date

Please send to:
Nevada State Board of Nursing
5011 Meadowood Mall Way, Suite 300
Reno, NV 89509
FAX: 775-687-7729 Phone: 1-775-687-7723