ATTENDANCE AT NURSE SUPPORT GROUP

Name of Nurse (PLEASE PRINT OR TYPE): _____

I am required to attend Nurse Support Group Meetings:

_____Once a week
_____Once a month
_____Twice a month
_____Other:_____

Verification of attendance for the month of:_____
(Month/Year)

DATE	FACILITATOR	SIGNATURE VERIFYING ATTENDANCE

Please send to: Nevada State Board of Nursing
5011 Meadowood Mall Way, #300
Reno, Nevada 89502
FAX: 775-687-7729
Phone 1-775-687-7723

Revision approved by the Disability Advisory Committee on October 19, 2007