

Employer's Report of Possible Violation(s) of the Law Relating to Practical Nursing
(PLEASE USE ADDITIONAL SHEET IF NECESSARY)

Full name of nurse being reported _____ License # _____

S.S. # _____ Nurse's address _____

Telephone# () _____ Street _____ City _____ State _____ Zip _____

Dates of employment FROM: _____ TO: _____

Nurse's position or title _____ Nurse's immediate supervisor _____

Unit Offense Occurred _____ Date or Cumulative Dates of Occurrence _____

Name of reporting facility _____ Administrator _____

Address _____ Telephone# () _____

Street _____ City _____ State _____ Zip _____
E-mail address _____ Fax # () _____ Name of D.O.N. _____

Name and Title of individual filing this report: _____

Was a drug screen performed? Yes No If yes, please submit a copy to include a copy of the chain of custody form.

Date and time specimen collected _____. If no, was drug screen refused? Yes No

Name and telephone# of Testing Lab _____ () _____

Name and Title of individual collecting specimen: _____

***Identify by title, all accompanying documentation and its relevance, highlight relevant individual entries on each document.**

- (1) _____
- (2) _____
- (3) _____
- (4) _____
- (5) _____
- (6) _____
- (7) _____
- (8) _____

Procedures taken concerning accused: _____ Terminated? Yes No,
if yes, date _____ Resigned? Yes No If yes, date _____

*Please include all documentation that pertains to your report of violation, eg.. nurses notes, copies of MARS, pyxis reports, time slips, prescriptions, witness statements, etc.

Previous Disciplinary (counseling) actions? Yes No, If yes, please include copies with your report.

Please attach a **signed** narrative statement from each witness listed below:

Witness: _____	Home address _____	Telephone#() _____
(Full name)	street city state zip	
Witness: _____	Home address _____	Telephone#() _____
(Full name)	street city state zip	
Witness: _____	Home address _____	Telephone#() _____
(Full name)	street city state zip	
Witness: _____	Home address _____	Telephone#() _____
(Full name)	street city state zip	

Describe fully the nature of the complaint: what occurred, when, date(s), time(s), where, etc. (use additional sheets as necessary)

Multiple horizontal lines for describing the complaint.

Was the nurse impaired on duty? Yes No If yes, please provide the full name and telephone number of any/all witnesses:

Witness: _____ Home address _____ Telephone#() _____
(Full name) street city state zip

Witness: _____ Home address _____ Telephone#() _____
(Full name) street city state zip

Witness: _____ Home address _____ Telephone#() _____
(Full name) street city state zip

PLEASE NOTE THAT YOU AND ANY WITNESS TO A VIOLATION COULD BE SUBPOENAED TO APPEAR AT A HEARING CONDUCTED IN THIS MATTER, IT IS IMPERATIVE THAT ALL INDIVIDUALS INVOLVED KEEP THE BOARD INFORMED OF ANY CHANGES IN ADDRESS OR TELEPHONE #.

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN AND THE DOCUMENTS ATTACHED HERETO ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE OF REPORTING OFFICIAL

DATE SIGNED

PLEASE MAIL OR FAX THIS FORM TO THE FOLLOWING:
LOUISIANA STATE BOARD OF PRACTICAL NURSE EXAMINERS
COMPLIANCE DEPARTMENT
3421 NORTH CAUSEWAY BLVD, SUITE 505
METAIRIE, LA 70002-3715
PHONE: 504-838-5791 FAX: 504-838-5279