# MAINE STATE BOARD OF NURSING

158 STATE HOUSE STATION
161 CAPITOL STREET
AUGUSTA, MAINE 04333-0158
**(207) 287-1138**

## APPLICATION FOR APPROVAL OF A SUPERVISING RELATIONSHIP WITH A LICENSED PHYSICIAN OR NURSE PRACTITIONER

A Certified Nurse Practitioner who qualifies as an Advance Practice Registered Nurse must practice, for at least 24 months, under the supervision of a licensed Physician or a *supervising Nurse Practitioner or must be employed by a clinic or hospital that has a Medical Director who is a license Physician. The Certified Nurse Practitioner shall submit written evidence to the board upon completion of the required clinical experience (32 M.R.S.A. §2012 (2)(A)).

**INSTRUCTIONS**

1. **Before the new Nurse Practitioner (NP) begins employment,** the NP must register a supervising relationship with the Board as part of the Authorization To Practice process.
2. **When modifying a supervisory relationship,** the NP must register the change on the provided form within 15 days of beginning employment. A $50.00 late registration fee will be assessed if this form is not filed within 15 days of beginning employment.
3. **If the Primary Supervising Physician or Nurse Practitioner will not be available at all times,** a Secondary Supervising Physician or Nurse Practitioner must be designated. This information must be included on the application.
4. **When a supervisory relationship is terminated,** the NP must notify the Board. The NP may use this form.
5. **At the end of the required twenty four months of supervision,** the NP must submit documentation of completion of the required clinical experience.

***NURSE PRACTITIONER SUPERVISORS:** The Nurse Practitioner must submit documentation to the Board of the following:

1. Completed 24 months of supervised practice;
2. Practiced as an Advanced Practice Registered Nurse for minimum of 5 years in the same specialty; and
3. Worked in a clinical health care field for a minimum of 10 years.

**Please Type or Print All Information Clearly** *(attach a separate page if more space needed)*

**Name of Nurse Practitioner Applicant** | **Maine License Number**

**Nurse Practitioner Applicant Mailing Address**

**Primary Supervising Physician/Nurse Practitioner** | **Maine License Number**

**Secondary Supervising Physician/ Nurse Practitioner** | **Maine License Number**

**Secondary Supervising Physician/ Nurse Practitioner** | **Maine License Number**

**REGISTRATION FEE is $50.00. You must submit a check or money order payable to the *"Treasurer State of Maine"* or complete the enclosed Credit Card Authorization Form.**

**Attach letter of supervision (synopsis of the services you will be providing) signed and dated by a licensed Physician or Nurse Practitioner in the same practice category and all secondary supervisors participating in this process.**

1. Name(s)/Address(s) of Practice Setting(s)
   *(**Start** date and hours per week **must be completed.** IF the start date if pending, please indicate that)*

Tel: ____________________

Start Date: __________ Hours per Week: __________

**Practice Type**
***(Please select one)***

☐ Office Practice

☐ Clinic

☐ Hospital (Department)

☐ Other (Explain)

2. Name(s)/Address(s) of Practice Setting(s)
   *(Start date and hours per week **must be completed.** IF the start date if pending, please indicate that)*

Tel: ____________________

Start Date: __________ Hours per Week: __________

**Practice Type**
***(Please select one)***

☐ Office Practice

☐ Clinic

☐ Hospital (Department)

☐ Other (Explain)

3. Name(s)/Address(s) of Practice Setting(s)
   *(Start date and hours per week **must be completed.** IF the start date if pending, please indicate that)*

Tel: ____________________

Start Date: __________ Hours per Week: __________

**Practice Type**
***(Please select one)***

☐ Office Practice

☐ Clinic

☐ Hospital (Department)

☐ Other (Explain)

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**Check appropriate box if supervisory relationship has ended.**

☐ Termination of a Primary Supervising Relationship during the twenty four month supervisory period.

**Please attach a letter signed by the Primary Supervising Physician or Nurse Practitioner indicating the time frame (beginning and end dates) and hours per week or total hours of supervision.**

**Name of Primary Supervising Physician or Nurse Practitioner:**

**Effective Date:** ____________________

**Reason for Termination:** ____________________

☐ Completion of the required twenty four month supervision requirement.

**Please attach a letter signed by the Primary Supervising Physician or Nurse Practitioner indicating the time frame (beginning and end dates) and hours per week or total hours of supervision.**

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**Signature of Applicant** **Date**