

*PEER ASSISTANCE PROGRAM OKLAHOMA BOARD OF NURSING*

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**Change of Supervisor Form**

Date \_\_\_\_\_ (Circle One): Temporary Permanent

**PLEASE PRINT THE FOLLOWING INFORMATION:**

\_\_\_\_\_  
Name of Nurse Participant

\_\_\_\_\_  
Name and address of Employer

\_\_\_\_\_  
Phone number and extension

\_\_\_\_\_  
New Supervising Nurse (Name, Title and License #)

\_\_\_\_\_  
Name of Supervising Nurse being replaced

Reason for the Change:  
\_\_\_\_\_

Effective Date: \_\_\_\_\_

[The new supervising nurse, the nurse manager and the nurse participant must all sign this form.]  
I have reviewed the existing Peer Assistance Program Contract and the Supervised Practice Agreement for the above-named Program participant and agree to assist this individual according to the terms of the contract and agreement.

\_\_\_\_\_  
Signature of New Supervising Nurse Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Nurse Manager Date \_\_\_\_\_

*I am aware of the change in my supervising nurse(s) effective \_\_\_\_\_ (date).*

\_\_\_\_\_  
Signature of Nurse Participant Date \_\_\_\_\_