Rick Scott
Governor

H. Frank Farmer, Jr., M.D., Ph.D.
State Surgeon General

Date________________

To: Division of Medical Quality Assurance
Florida Board of Nursing
4052 Bald Cypress Way, Bin #C02
Tallahassee, FL 32399-3252

This is to notify you that I, ____,
(Please Type or Print First, Middle and Last Name)

licensed as a ___________in the State of _______________, License Number ____________,
(LPN, RN, ARNP)

will be accompanying and caring for ____,
(Please Type or Print Patients First, Middle and Last Name)

in the State of Florida from _________________ through _________________.
(MM/DD/YYYY) (MM/DD/YYYY)

I am aware of and in compliance with **ALL** of the below listed requirements of the Florida Nurse Practice Act. (Please Initial).

______ Patient is not in an inpatient setting.

______ Visit is for no more than 30 consecutive days.

______ I am in possession of the patient's standing physician orders and current medical status.

______ I have made pre-arrangements with the appropriate health care providers in Florida should the patient require placement in an inpatient setting. (Basically, I am aware of the location of the appropriate health care provider/facility in the area being visited by the patient under my care.)

____________________________ (Signature)

____________________________ (License Number)

____________________________ (Street Address)

____________________________ (State of Issuance)

____________________________ (City, State and Zip Code)

____________________________ (Daytime Telephone Number)

____________________________ (Email Address)