Nevada State Board of NURSING

After Care

Name of nurse: _____

(Please print or type)

I am required to attend Aftercare that consists of:

- 2 individual counseling session each month (minimum)
- Weekly group counseling sessions

Verification of attendance for the month(s) of: _____

(Months/Year)

INDIVIDUAL

Date	Counselor	Signature Verification

GROUP

Date	Counselor	Signature Verification

E-mail completed forms to: compliance@nevadanursingboard.org or;
Fax completed forms to: 775-687-7729 (Please do not fax multiple copies) or;
Mail to: NSBN, Compliance Coordinator, 5011 Meadowood Mall Way, Ste 300, Reno, NV 89502-6576