

*** COMPANION APPLICATION ***

Dear VACC Camp Applicant:

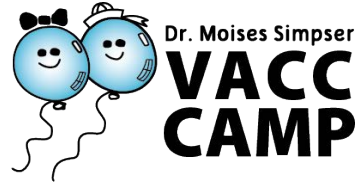
You have expressed a need to have your home care nurse or respiratory therapist attend VACC Camp with your family. To introduce this person to us, please complete and return the Companion Application as well as proceed with the requirements with the State of Florida to accompany the camper to Miami (form enclosed).

Email the completed application to bela.florentin@nicklaushealth.org. The notification letter for the Florida Board of Nursing should be sent to the address on their form, please email us a copy too.

Don't hesitate to call if we might be of further assistance in this matter.

Cordially,

Bela Florentin
VACC Camp Coordinator



***** COMPANION APPLICATION *****

If our family is invited to VACC Camp, in order to attend we would need to have our
__ home care nurse __ respiratory therapist come to camp with us.

This is necessary because _____
_____.

The nurse/therapist who would attend camp with us is:

Name: _____

Agency: _____

Street: _____

City: _____ State: _____ Zip: _____

Phone: _____

ATTACH A COPY OF THE NURSE/THERAPIST'S CURRENT LICENSE

Nurse/Therapist's Signature

Parent/Guardian's Signature

Date: _____

PRINT Parent/Guardian's Name

RETURN TO:

Dr. Moises Simpson VACC Camp
Nicklaus Children's Hospital
3200 SW 62nd Ave
Suite 203
Miami, Florida 33155-4076

Phone:
(305)662-VACC or 662-8380

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

Vision: To be the Healthiest State in the Nation

EXCEPTION TO NURSE PRACTICE ACT AND NOTIFICATION REQUIREMENTS TO ACCOMPANY AND CARE FOR A PATIENT TEMPORARILY RESIDING IN FLORIDA

The Florida Legislature granted an exception to Chapter 464, Florida Statutes, the Florida Nurse Practice Act for a legally qualified nurse of another state whose employment requires the nurse to accompany and care for a patient temporarily residing in Florida. Florida Statutes, Section 464.022(12), reads as follows:

"The practice of nursing by an legally qualified nurse of another state whose employment requires the nurse to accompany and care for a patient temporarily residing in this state for not more than 30 consecutive days, provided the patient is not in an inpatient setting, the board is notified prior to arrival of the patient and nurse, the nurse has the standing physician orders and current medical status of the patient available, and prearrangements with the appropriate licensed health care providers in this state have been made in case the patient needs placement in an inpatient setting."

The nurse must provide notification to the Division of Medical Quality Assurance, Board of Nursing prior to arrival in Florida. The notification must include the nurse's name (as it appears on the license), jurisdiction in which licensed is held, and license number and the address of the nurse. Also, the notification must include an affirmation that the nurse has the standing physician orders and current medical status of the patient and that prearrangements with the appropriate licensed health care providers in Florida have been made in case the patient needs placement in an inpatient setting. We encourage you to use the enclosed letter of notification.

Notification letters should be sent to:

**Florida Board of Nursing
4052 Bald Cypress Way
BIN CO2
Tallahassee, Florida 32399-3252
or FAX: (850) 617-6460**

If you have any questions or need additional information, you may email us at: MQA_Nursing@doh.state.fl.us.

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Vision: To be the Healthiest State in the Nation

Date: _____

To: **Division of Medical Quality Assurance**
Florida Board of Nursing
4052 Bald Cypress Way, Bin #CO2
Tallahassee, FL 32399-3252

This is to notify you that I, _____
(Please type or print First, Middle and Last Name)

licensed as _____ in the State of _____, License Number _____
(LPN, RN, ARNP)

will be accompanying and caring for _____
(Please type or print patient's 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 each requirement).**

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. 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

Email Address

Street Address

Agency Name (if applicable)

City, State and Zip Code

Agency Telephone Number (if applicable)

Daytime Telephone Number

Agency Fax Number (if applicable)