TEXAS PEER ASSISTANCE PROGRAM FOR NURSES

TPAPN REFERRAL DOCUMENTATION

Please complete all fields on this form. If emailing form, **save** the file and send as an attachment. Otherwise, **print** and mail or fax.

INFORMATION ABOUT PERSON REFERRING NURSE

First Name | Last Name

Title | Place of Employment

Facility Address

City | TX | ZIP

Telephone | Email

Relationship to Nurse | Other

INFORMATION ABOUT NURSE BEING REFERRED

First Name | Last Name | Phone

Home Address | City | TX | ZIP

Texas Nursing License Number | Expiration Date

Title RN | APRN License #

Age | Date of Birth | FEMALE

Job Status When Referred Employed | Length of Employment | Type of Employment

Facility Name [same as above] ☐ [if different]

Current Area of Practice | Reason for Referral Select

REQUIRED: Please provide detailed information about the referral reason and/or circumstances including any possible practice violations.

Please use additional pages as needed.

Text entered here will continue into the the next page. However, copy-pasted text will not automatically continue to the next box. You will need to paste information separately into the next page.

Form Completed By | Date

Contact **TPAPN** at **1.800.288.5528** for any questions regarding making a referral.

Include supportive documentation, i.e., drug test results, etc.
Third party referral sources must fax a copy to the Board of Nursing at 512.305.7401.
Click here for the Texas Board of Nursing complaint form or go to Texas Board of Nursing.

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Continued: Information about the referral reason and/or circumstances