



Oregon State Board of Nursing

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Nurse Monitoring Program Participant Report

Please complete and sign this form and fax it to the OSBN office at: 971-673-0683.

Reporting Date: _____

Name: _____

Phone: _____ (Is this a change? Circle: Yes / No)

Change Of Address? _____

E-Mail Address: _____

Work Information

Current Manager/Supervisor (if changed): _____

Contact number: _____

E-mail if applicable: _____

Treatment Information

How many treatment meetings did you attend? (Primary Care Physician, Nurse Practitioner, Counselor, etc.) _____

List names of meetings/appointments and dates attended:

Have you changed therapist/treatment provider/prescribers? Please circle: yes / no

If yes, please list:

Name: _____ Phone: _____

Name: _____ Phone: _____

Release of Information signed (please circle): yes / no

Changes in medication (If yes, fill out medication form): _____

Recovery Information

How many support groups/meetings/counseling did you attend?
(12 step, Celebrate Recovery, Smart Recovery, Women for Sobriety, etc.) _____

List names of meetings/appointments and dates attended:

List any other community involvement/activities: _____

Sponsor/Mentor Information *(for those with a substance use disorder):*

My sponsor's expectations of me are: _____

My sponsor/mentor and I plan to meet _____ times per _____

We will work on the following: (include step work, workbooks, other recovery guides, meetings you attend together, etc.) _____

General Updates/Summary

Any health concerns? Please circle: Yes / No

If yes, please explain: _____

Current Stressors? _____

Employment changes or anticipated changes? Please circle: Yes / No

If yes, please explain: _____

For those with substance use issues: Have there been any issues/concerns regarding handling and access to controlled substances? Please circle: Yes / No

If yes, please explain: _____

Classes you are involved in or plan to attend? _____

Participant Signature

Date

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