



Oregon State Board of Nursing

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Nurse Monitoring Program Participant Prescription Use Form

*Please complete and sign this form and fax it to the OSBN office at: 971-673-0683
or mail to the address above.*

Name of Participant: _____
(please print)

Use of controlled substances while on the Nurse Monitoring Program is restricted to absolute need and justification by a prescriber.

You must have your health care practitioner complete the table below regarding any controlled substances/narcotics she/he prescribes for your medical condition.

You must then fax or mail this form and copies of any prescriptions to the OSBN Nurse Monitoring Program office.

Prescription Information			
Date Of Prescription	Type Of Medication	Quantity & Dosage Prescribed/Number Of Refills	Reason For Medication/Length Of Treatment

Can this patient continue to practice nursing while taking these medications? ___Yes ___No

If no, when can this patient return to nursing duties? _____(date)

Comments: _____

**I have been informed this patient is in recovery for chemical dependency
or mental health diagnosis.**

Practitioner Name (Please Print)

Practitioner Signature (required)

Practitioner Office Phone Number

Date