



**Oregon State Board of Nursing**

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Nurse Monitoring Program: 971-673-0655

# Terms and Conditions for Nursing Practice During Participation in the Nurse Monitoring Program

## Licensee

I, \_\_\_\_\_, RN, agree to comply with the following terms and conditions related to nursing practice at \_\_\_\_\_, during my participation in the Nurse Monitoring Program. I confirm that my employer is aware of my participation in the Monitoring Program.

- I will not seek or accept other nursing positions without prior approval of the Nurse Monitoring Program.
- I agree that I will advise the Nurse Monitoring Program of potential changes in employment situation to verify if the worksite and level of supervision are appropriate for my nursing practice.
- I agree to the following conditions as they relate to my current position:
  - I may work up to 40 hours a week. May work in only one setting.
  - I may occasionally work overtime hours to finish a shift.
  - I may NOT have access to narcotics and controlled substances in the workplace.
- I agree that I will immediately notify the Nurse Monitoring Program if my co-workers question my sobriety while I am practicing nursing. I further agree that I will insist upon immediate urinalysis or blood testing to verify I am not practicing under the influence of unauthorized substances.
- I understand that the Nurse Monitoring Program and my supervisor will advise each other of any failure on my part to comply with the terms and conditions of the Nurse Monitoring Program within 24 hours.
- I agree to cease nursing practice upon the occurrence of a relapse or at the request of the Nurse Monitoring Program because of relapse or relapse behavior. Practice may resume when approved by the Nurse Monitoring Program Coordinator, in consultation with my employer.
- I understand that this contract will be reviewed one year from the date of signing and revisions will occur as agreed upon by the Nurse Monitoring Program, my employer, and by myself.
- I agree that no changes will be made to this contract without prior approval of the Nurse Monitoring Program.

\_\_\_\_\_

Date

\_\_\_\_\_  
Coordinator, Nurse Monitoring Program

\_\_\_\_\_  
Date

**Please Sign And Return To The Nurse Monitoring Program**