Prescription Information Form

Name of Participant: ___________________________________________________________
(please print)

Use of controlled substances while on Probation 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 or narcotics she/he prescribes for your medical condition.

You must then fax or mail this form and copies of any prescriptions to the OSBN Investigations Dept.

<table>
<thead>
<tr>
<th>DATE OF PRESCRIPTION</th>
<th>TYPE OF MEDICATION</th>
<th>QUANTITY &amp; DOSAGE PRESCRIBED/NUMBER OF REFILLS</th>
<th>REASON FOR MEDICATION/LENGTH OF TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Release has been signed to allow communication with the Board? __________ (yes/no)

Can this patient continue practicing/performing duties 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 on probation and has a chemical dependency or mental health diagnosis.

___________________________________________________________  ____________________________
Practitioner Name (Please Print)                              Practitioner Signature

___________________________________________________________
Practitioner Office Phone Number

___________________________________________________________
Date