FORM I

Ohio Board of Nursing www.nursing.ohio.gov
17 South High Street, Suite 400 • Columbus, Ohio 43215-7410 • (614) 466-3947

PERSONAL REPORT FORM

Instructions: Complete this form and **mail the original** to the Board postmarked on or by the first day of each reporting month according to the Report Schedule. Forms will not be automatically supplied to you. You may copy the reporting form as needed or obtain a copy of the form under "Forms" on the Board's website. **You are required to keep copies of all reports for the duration of your Agreement.**

Report for the month/year of: _____ Participant Name: _____

Has your mailing address or phone number changed? Yes _____ No _____

Provide the new information and effective date: _____

_____

EMPLOYMENT

Have there been any changes in your current employer, employment status, hours worked, or work site monitor? If yes, explain. Please note you must attach the appropriate program documentation indicating the change.

_____

_____

Have you complied with all employment terms and conditions? Yes _____ No _____

Explain: _____

_____

Note your hours worked during the reporting period.

_____

_____

Note any problems/concerns regarding employment, including verbal or written warnings, counseling or disciplinary action.

_____

_____

CHEMICAL DEPENDENCY TREATMENT

Are you currently attending chemical dependency treatment? Yes _____ No _____

What phase of treatment are you in and how often are you scheduled to attend?

_____

_____

List the dates you attended treatment sessions. Explain any absences (excused or unexcused).

_____

_____

Have you been referred to any other treatment practitioner(s)/provider(s) by your chemical dependency treatment program? If yes, explain:

_____

_____

MEDICAL/MEDICATIONS

List **ALL** prescription or over-the-counter medications, vitamins and herbal substances taken this month and the reasons for use:

_____

_____

If there are any changes in your medication list, an updated medication form signed by the legally authorized prescriber must be provided.

Are you scheduled for any appointments, medical/dental procedures, or surgery? Yes _____ No _____

If yes, provide the healthcare professional's name and appointment, procedure, and/or surgery date(s):

_____

Were you selected for a drug screen since your last report? Yes _____ No _____

Attach a client copy of your Chain of Custody (COC) form for that specimen to this report.

LEGAL ISSUES

Have you violated any federal, state or local law since submission of your last personal report?
Yes _____ No _____

Are you currently on probation/community control? Yes _____ No _____

Current legal issues/status_____

_____

RECOVERY ACTIVITIES

In a narrative, describe the frequency of contact with your sponsor and home group, current step work, and how you are integrating the principles of your 12 step support group and/or other support group into your personal and professional life:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please provide any information, including any and all healthcare and chemical dependency treatment plans, of which you would like your Monitoring Agent to be aware and that has not been previously discussed. If additional space is needed, please use the reverse side of this form.

I attest that all information I have provided is true and factual.

_____ _____
Participant Signature Date

Effective April 2015