



# Ohio Board of Nursing

[www.nursing.ohio.gov](http://www.nursing.ohio.gov)

17 South High Street, Suite 400 • Columbus, Ohio 43215-7410 • (614) 466-3947

## HEALTHCARE PROVIDER EVALUATION FORM

**Please submit this form directly to the Ohio Board of Nursing's Alternative Program for Chemical Dependency/Substance Use Disorders by mail or by fax (#614-466-0710).**

Participant Name: \_\_\_\_\_

Healthcare Practitioner: \_\_\_\_\_ Phone: \_\_\_\_\_

Date and Purpose of Visit: \_\_\_\_\_

Rule 4723-6-03(B), Ohio Administrative Code, requires all Participants to remain alcohol and drug free except for medications prescribed by a legally authorized prescriber and that the Participant inform all practitioners of their chemical dependency and recovery status **prior to receiving** any treatment and/or prescription(s).

**The above named Participant has informed me of his/her chemical dependency history and recovery status prior to my provision of treatment and/or prescriptions?    Yes \_\_\_\_\_    No \_\_\_\_\_**

**Diagnosis:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Treatment:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Recommendations:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

