Form 6

Ohio Board of Nursing *www.nursing.ohio.gov*

17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

MEDICAL REPORT

As the treating practitioner, the Board of Nursing Compliance Unit requests that you please take a few moments to complete this form. **Please submit the report directly to the Compliance Unit Monitoring Agent.**

(check one)

Nurse's Name_____ Initial report_____

Progress report ___

Name of Provider (please print) _____

Address_____

Phone ( )_____ Fax ( )_____

Please describe nurse's progress relative to the treatment plan. Include current status and progress made.

_____

_____

_____

Medications prescribed_____

_____

FOR INITIAL REPORTS ONLY (UNLESS CHANGES OCCUR):

Nurse's diagnosis (if appropriate) _____

_____

Please describe treatment plan for this nurse. _____

_____

_____

For initial report only: Have you received copy of the nurse's Consent Agreement or Board Order?
YES ____NO____

_____

Practitioner signature/ Date

FORM MAY BE PHOTOCOPIED

NUR 6504