PEER ASSISTANCE PROGRAM

OKLAHOMA BOARD OF NURSING

Contact: 2501 N. Lincoln Blvd. ● SUITE 217 ● OKLAHOMA CITY, OKLAHOMA 73105-4508 ●
US Postal Delivery: PO Box 52926 Oklahoma City, OK 73152
(405) 525-2277 ● https://oklahoma.gov/nursing.html ● Fax (405) 525-0350

Healthcare Provider Acknowledgment Form

I certify that I am a healthcare provider for:_____.

I acknowledge that my patient is an applicant/participant in the Peer Assistance Program and has provided me a copy of the Program's Medical Care/Medications Guidelines.

I understand that the Peer Assistance Program was established by the Oklahoma Legislature and regulated by the Oklahoma Board of Nursing to monitor the rehabilitation and practice of nurses whose competency may be compromised because of the abuse of alcohol and/or drugs.

I acknowledge that my patient is a nurse and, when practicing, is responsible for patient care. I understand that if, at any time, I have a concern about my patient's ability to practice nursing with reasonable skill and safety, I am to report my concerns to the Peer Assistance Program Coordinator and/or Case Manager.

I acknowledge that my patient should avoid the use of mind altering, intoxicating and potentially addictive substances. I agree to avoid the use of these substances in the treatment of my patient, when possible. I am aware that the use of mind altering, intoxicating and potentially addictive substances may put my patient at risk for relapse, interfere with treatment, and impact my patient's ability to practice nursing safely. When the use of these substances is indicated, I will document the rationale and my plan of treatment and provide such documentation to the Peer Assistance Program immediately upon the initiation of such treatment.

I acknowledge that some over the counter medications and herbal preparations also have potential risks to individuals in recovery. The Program discourages the use of these over the counter medications unless authorized by the healthcare provider. When the use of these medications is indicated, I will immediately provide documentation to the Peer Assistance Program.

I understand I may be asked to collaborate with an Addictionist or Addiction Psychiatrist in the management of my patient's medications and I agree to do this.

I understand my patient is required to utilize only one primary care provider, one dentist and one pharmacy while in the Program. All medications must be prescribed and filled through the identified providers unless I have made a referral to another provider. My patient is to follow up with me within 7 days of receiving any emergency treatment from a different provider.

I have read this form and agree to follow the terms as described. I understand that if I am unable to follow the terms as described, I will refer my patient to another healthcare provider. If I have any questions, I will contact the Peer Assistance Program Coordinator and/or Case Manager at (405) 525-2277.

Please sign and mail/fax this form to the Peer Assistance Program at PO Box 52926, Oklahoma City, OK 73152. 405-525-0350

_____ _____
Healthcare Provider (please print) Date

_____ _____
Healthcare Provider signature Phone Number