



GEORGIA BOARD OF NURSING
237 Coliseum Drive
Macon, GA
31217-3858

Continuing Care/Aftercare Support Group Report

Please complete this form and return it to the address shown above by reporting period ending on March 31st, June 30th, September 30th, and December 31st.

Report On _____ License Number _____
(Print name of nurse Attending Support Group) (Please write license number)

Reporting Period _____ Date Joined Support Group _____

Number and Type of 12 Step Meetings attended per week _____

Number of Group Meetings attended since last report _____

Number of Group Meetings missed since last report _____

Drug Screen Results (list date administered & results. Attach a copy of all positive results).

Substance/Drug Identified _____

Comments _____

Recommendations made to Nurse (if any) _____

List any medication prescribed _____

Signature of Facilitator (DATE)

Agency

Printed Name & Title

Address

Telephone Number

City/State/Zip

(If you have additional comments, please use the page provided on the website.)



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Employer Quarterly Report Form

Instructions to employer: Please complete this form to assist the Board of Nursing in monitoring the practice of this nurse. **ALL** reports should be mailed to the Board office by reporting period ending March 31st, June 30th, September 30th, and December 31st.

Reporting Period Ending _____ Supervisor's Name _____

Name of Licensee _____ License Number _____
(Must include license number)

Name of Facility _____

Address _____

City _____ State _____ Zip _____

Phone Number _____

Licensee's Area of: Specialty _____

Position _____

Schedule _____

Categories	S	U	Comments
Attendance			
Quality of Work			
Attitude			
Compliance with Aftercare			
Random Drug Screens			
Compliance with Controlled Substances Restriction			

Signature of Preparer _____

Printed Name of Preparer _____

Title of Preparer _____

Date _____

(If you have additional comments, please use the page provided on the website.)



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Personal Quarterly Report

Please complete this form and return it to the address shown above by reporting period ending on March 31st, June 30th, September 30th, and December 31st.

Licensee Information:

Name of Licensee _____
(Must be the same as listed on license)
Reporting Period Ending _____ License Number _____
(Must include license #)
Address _____ Home Phone Number _____
City _____ State _____ Zip Code _____

Employment Information:

Place of Employment _____
Address _____ Phone Number _____
City _____ State _____ Zip Code _____

Other:

Health Status _____

List any over-the-counter medications taken. Prescribed meds must be reported on the Medication Management Reporting Form.

Comments _____

Signature _____ Date _____

(If you have additional comments, please use the page provided on the website.)



GEORGIA BOARD OF NURSING
237 Coliseum Drive * Macon, Georgia 31217-3858

Psychotherapist/Professional Counselor Quarterly Report

Please complete this form and return it to the address shown above by reporting periods ending on March 31st, June 30th, September 30th, and December 31st.

Name of Nurse _____ License Number _____
(Must be the same as listed on license) (Must be completed)

Reporting Period Ending _____ Date therapy began _____

Number of appointments scheduled this period _____

Number of appointments licensee missed/cancelled this period _____

Indicate the reason provided for missed/cancelled appointments _____

Current diagnosis _____

Current treatment recommendation(s) _____

Is continued psychotherapy recommended? (circle one) YES NO

If any medications were prescribed, adjusted or discontinued, the Medication Management Reporting Form must be completed.

Signature of Psychotherapist _____ Name of Agency/Organization _____

Printed Name & Title _____ Address _____

Telephone Number _____ / _____ Date Completed _____ City/State/Zip _____



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Medication Management Reporting Form

This form must be submitted by all licensees who are practicing under the terms of a consent order/agreement and require prescription medications. Please complete one form per prescribing physician.

Name of Nurse _____ License Number _____
(Must be the same as listed on license) (Must be completed)

Reporting Period Ending _____

Date of Prescription	Name of Medication	Dosage, Quantity & Number of Refills	Reason Prescribed

Printed Name of Healthcare Provider _____

Signature of Healthcare Provider _____

Name of Facility/Business: _____

Facility Address: _____
(Street/Mailing Address) (City/State/Zip)

Telephone: _____ **Date** _____

