



GEORGIA BOARD OF NURSING

How do I voluntarily report that I am chemically dependent or abusing drugs/alcohol?

The Georgia Board of Nursing is charged to protect the health, safety and welfare of the general public and licensed professionals through early recognition and intervention for nurses who may abuse drugs/alcohol or be chemically dependent.

To that end, this packet is available for nurses who have:

- 1) Tested positive on a drug screen for any drug contained in Schedule I through Schedule VI of the Controlled Substances Act and/or any drug for which you cannot provide a legitimate prescription;
- 2) Been the subject of a substance abuse intervention based on abuse of any drug with or without a legitimate prescription; and/or
- 3) Recognized that you have become chemically dependent or engaged in abuse of drugs/alcohol.

Enclosed you will find a Self Report form and Consent to Release Records form. Please read the Self Report form carefully and complete it in its entirety. If a question is not relevant to your circumstance, indicate N/A (not applicable) in response to that question. The Self Report Form may be submitted to the Board by fax to (877) 371-5712 or by mail to:

Georgia Board of Nursing
237 Coliseum Drive
Macon, Georgia 31217-3858

By taking the step to self report, it is likely that you have entered or recently completed a treatment program; however, **if you have not entered treatment and/or obtained a substance abuse assessment by a physician who specializes in addiction, you must obtain an assessment immediately at your own expense.**

All nurses are expected to fully comply with the recommendations and treatment plan of that treatment provider to include practice restrictions/limitations.

Complete and sign the Consent to Release form and have it notarized. Provide the original form to your treatment provider so that they may release your records to the Board for review. You are responsible for ensuring that the documents are submitted to the Board which includes payment of any fees associated with the production and distribution of these records.

The completed self report form and records will be presented to the Board and/or its designee for investigation and review. **As a licensed nurse, you have a professional responsibility under the law and board rules not to work unless you are able to practice nursing with reasonable skill and safety. You should work only if you are not impaired by alcohol, drugs, narcotics, chemicals, or a mental or physical condition, and you hold a renewed and active license.**

The Board is required to send documentation of the final decision to the nurse's address of record. By law and board rule, a nurse is required to notify the Board of any address changes (including current email address information, if applicable).

By submitting a signed self report form you are agreeing to notify the Board in writing of any changes in your condition (i.e. medical, employment, address changes, etc.), inform any current or prospective employers that your ability to practice as a nurse is under review by the Board, authorize the Board and/or its designee to contact any current or prospective employers regarding your practice, continue to participate in a program for chemical dependence and maintain full compliance with your treatment plan. Most importantly, you agree to refrain from practicing while impaired. If you have additional questions, please call (478) 207-2440.

The Board appreciates your adherence to your professional obligation to report your impairment concerns to the Board.



GEORGIA BOARD OF NURSING (RN/LPN) SELF REPORT FORM

COMPLETE ALL FORMS IN THEIR ENTIRETY.
INDICATE N/A WHERE APPROPRIATE

Name: _____ Georgia License Number: _____

Name of Substance(s) Abused _____

Method of Obtaining Substance (Check all that apply):

- Prescription Fraud/Forgery Diversion from the workplace
 Diversion directly from patients Abuse/Misuse of Prescription Drugs
 Drug Seeking through physicians/practitioners Alcohol Abuse/Dependence
 Other (Explain) _____

Where and when did the incident occur? Name/Address of _____

Date Occurred _____

Were you employed at the location where the incident occurred? Yes No

If yes, who was your supervisor or DON at that location? Name/Title: _____

Phone Number: _____

Email Address: _____

TREATMENT INFORMATION:

Did you enter treatment? Yes No

If "NO," YOU ARE ENCOURAGED TO SEEK TREATMENT IMMEDIATELY

If "YES," enter below the name of your treating physician and address of treatment facility.

YOU MUST CAUSE YOUR TREATMENT PROVIDER TO SUBMIT CERTIFIED COPIES OF YOUR TREATMENT RECORDS, TO INCLUDE THE ADMISSIONS ASSESSMENT, LIST OF MEDICATIONS, DIAGNOSIS AND TREATMENT PLAN TO THE BOARD. ANY COST ASSOCIATED WITH THE PRODUCTION OF THIS DOCUMENTATION MUST PAID BY THE LICENSEE.

Date entered treatment: _____ Estimated completion date: _____

DISCIPLINARY AND CRIMINAL ARREST/CONVICTION INFORMATION:

Were you terminated as a result of the incident? ___ Yes ___ No

If "NO", were you disciplined and/or did you enter an employee impairment program after the incident? ___ Yes ___ No
Explain any "Yes" response to this question _____

Did you work while impaired? ___ Yes ___ No Were you terminated as a result of your impairment? ___ Yes ___ No

Are you currently working as a RN or in the area of healthcare? ___ Yes ___ No

If "YES," enter name, address, and contact number of the employer(s): _____

Were you arrested or charged with an offense as a result of your impairment / crime? ___ Yes ___ No

If so, name the county/state/court where the arrest/charge occurred. _____

You must submit a certified copy of the final disposition of your case. If the case has not yet gone to court and no final disposition is available, provide a copy of the arrest report or citation.

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Upon signing this document, you agree to: 1) Notify the Board in writing of any change in employment; 2) Inform any current or prospective employers that your ability to practice is under review by the Board; 3) Authorize the Board and/or its designee to contact any past, current or prospective employers regarding your practice; 4) Continue to participate in a program for chemical dependence and maintain full compliance with your treatment plan; and 5) Refrain from practicing while impaired.

Signature: _____

Date: _____

Please return this form immediately to:

Georgia Board of Nursing
237 Coliseum Drive, Macon, Georgia 31217-3858
Telephone (478) 207-2440 / Fax: (877) 371-5712

CONSENT TO RELEASE RECORDS

TO: _____

(Fill in name and address of facility where examination is performed)

I, _____, do hereby consent to and authorize the release of any and all records, including alcohol and drug treatment and psychiatric records, and any records of previous examinations or treatments, which may be necessary for a current assessment of my mental/physical condition, to the Georgia Board of Nursing or a designee of the Board. I understand that this disclosure is for use by the Georgia Board of Nursing in its investigation concerning my fitness to practice as a registered professional nurse in the State of Georgia, pursuant to the provisions of O.C.G.A. Title 43, Chapter 26, Article 1 and O.C.G.A. § 43-1-19(h).

I understand that this consent is subject to revocation at any time, except to the extent that action has been taken in reliance thereon, or as provided by federal law.

Signature of Licensee
GA License # _____

Licensee swore to and subscribed before me this _____ day of _____, 20____.

NOTARY PUBLIC
My commission expires: