Georgia
Board Of Nursing

Addiction Medicine Physician Quarterly Report Form

Please complete this form and return it to the Board at the end of the reporting period (March 31, June 30, September 30, December 31). Documentation should be emailed to nursingcompliance@sos.ga.gov . Licensees should maintain a copy of all reports submitted until their probation is terminated.

Licensee:
License Number:
Reporting Period End Date:
Number of Appointments Scheduled During This Period:
Number of Appointments Missed/Cancelled During This Period:
Reason for Missed/Cancelled Appointments:
Current Diagnosis:
Current Treatment Recommendations:
Is Continued Treatment Recommended? ◯Yes ◯ No If no, please submit documentation from the treatment provider explaining why treatment is no longer required.
Current Meds:
If Suboxone, Methadone, or any like drug is prescribed, is the licensee safe to practice nursing while taking? ◯ **Yes** ◯ **No**

Printed Name of Physician:	Agency/Organization:
Physician Signature:	Date:
Address:	
City:	State: Zip
Phone:	Email:

Georgia
Board Of Nursing

Continuing Care / Aftercare Support Group
Quarterly Report Form

Please complete this form and return it to the Board at the end of the reporting period (March 31, June 30, September 30, December 31). Documentation should be emailed to nursingcompliance@sos.ga.gov . Licensees should maintain a copy of all reports submitted until their probation is terminated.

Aftercare Participant:	
Aftercare Participant License Number:	Reporting Period End Date:
Date Joined Support Group	
Number of Group Meetings Attended Since Last Report:	
Number of Group Meetings Missed Since Last Report:	
Drug Screen Results (List Date Administered and Results. Attach a copy of all positive results):	
Substance/Drug Identified:	
Is participant in compliance? D Yes D No Comments:	
Recommendations made to Nurse:	
List any prescribed medications and herbal supplements:	
Facilitator Printed Name:	Agency:
Facilitator Signature:	Date:
Address:	
Telephone:	Email:

Georgia
Board Of Nursing

Employer
Quarterly Report Form

Please complete this form and return it to the Board at the end of the reporting period (March 31, June 30, September 30, December 31). Documentation should be emailed to nursingcompliance@sos.ga.gov . Licensees should maintain a copy of all reports submitted until their probation is terminated.

Licensee:		
License Number:		
Reporting Period End Date:		
Name of Employer:		
Address:		
City:	State:	Zip
Phone:	Email:	
Licensee's Position: Licensee's Schedule:		

Categories	S	U	Comments
Job Efficiency: Has the nurse generally met job requirements? Have there been any recent medication errors?			
Difficulty in Concentration: Has the nurse generally been engaged with coworkers? Has the nurse had issues with documentation?			
Attendance: Has the nurse had any unexcused absences? Has the nurse had any issues with tardiness?			
Compliance with Controlled Substance Restrictions (if applicable)			

Printed Name of Supervisor:	Title of Supervisor:
Signature of Supervisor:	Date:

Georgia
Board Of Nursing

Personal
Quarterly Report Form

Please complete this form and return it to the Board at the end of the reporting period (March 31, June 30, September 30, December 31). Documentation should be emailed to nursingcompliance@sos.ga.gov . Please maintain a copy of all reports submitted until your probation is terminated.

Licensee:		
License Number:	Reporting Period End Date:	
Address:		
City:	State:	Zip
Phone:	Email:	
Name of Employer:		
Address:		
City:	State:	Zip
Phone:	Email:	
Health Status:		
For licensees who are in aftercare and/or required to undergo random drug testing (follicle, urine): Include prescription medications on the List of Prescription Medications Form. Please list all over the counter medications or herbal supplements you are currently using:		
Additional Comments:		
Licensee Printed Name:		
Licensee Signature:	Date:	

Georgia
Board Of Nursing

Psychotherapist/Professional Counselor
Quarterly Report Form

Please complete this form and return it to the Board at the end of the reporting period (March 31, June 30, September 30, December 31). Documentation should be emailed to nursingcompliance@sos.ga.gov . Licensees should maintain a copy of all reports submitted until their probation is terminated.

Licensee:		
License Number:		
Reporting Period End Date:		
Number of Appointments Scheduled During This Period:		
Number of Appointments Missed/Cancelled During This Period:		
Reason for Missed/Cancelled Appointments:		
Current Diagnosis:		
Current Treatment Recommendations:		
Is Continued Psychotherapy Recommended? D Yes D No If no, please submit documentation from the treatment provider explaining why treatment is no longer required.		
If any medications were prescribed, adjusted or discontinued, the List of Prescription Medications Form must be completed.		
Printed Name of Psychotherapist:	Agency/Organization:	
Psychotherapist Signature:	Date:	
Address:		
City:	State:	Zip
Phone:	Email:	

Georgia
Board Of Nursing

Medication Management Report Form

All licensees who are practicing under the terms of a consent order/agreement who are required to submit quarterly medication management reports must submit this form. This form must be completed by a single physician and include every medication prescribed (even if there are several prescribers). Documentation should be emailed to nursingcompliance@sos.ga.gov at the end of the reporting period (March 31, June 30, September 30, and December 31). Licensees should maintain a copy of all reports submitted until their probation is terminated.

Licensee:				
License Number:				
Reporting Period End Date:				
Date of Prescription	Medication	Dosage, Quantity and Number of Refills	Prescriber	Reason Prescribed

Printed Name of Healthcare Provider:	Agency/Organization:
Healthcare Provider's Signature:	Date:
Address:	

City:	State:	Zip
Phone:	Email:	

Georgia
Board Of Nursing

List of Prescription Medications

All licensees who are practicing under the terms of a consent order/agreement and are prescribed medications must submit this form. If a licensee is prescribed any new medication, an updated copy of this form must be submitted to the Board within ten (10) days. Documentation should be emailed to nursingcompliance@sos.ga.gov .
Licensees should maintain a copy of this document until their probation has been terminated.

Licensee:				
License Number:				
Reporting Period End Date:				
Date of Prescription	Medication	Dosage, Quantity and Number of Refills	Prescriber	Reason Prescribed

Printed Name of Healthcare Provider:	Agency/Organization:
Healthcare Provider's Signature:	Date:
Address:	

City:	State:	Zip
Phone:	Email:	