Georgia
Board Of Nursing

Self-Report Packet

The Georgia Board of Nursing is charged to protect the health, safety and welfare of the public through early recognition and intervention for licensed professional nurses who may abuse or be chemically dependent on drugs/alcohol. The Self Report packet is available for any nurse who has:

1) Abused or become chemically dependent on drugs/alcohol.
2) Tested positive on a drug screen for alcohol and/or any drug contained in the Schedule I through Schedule V of the Controlled Substances Act (without a legitimate prescription)
3) Completed or enrolled in substance abuse treatment (alcohol, illegal drugs/substances and prescription drugs-with or without a legitimate prescription)
4) Diverted medications from patients/workplace

Please read and complete the Self-Report Form in its entirety. If a question is not relevant to your circumstance, indicate not applicable (N/A) in response to that question. The Self-Report Form should be submitted to the board office by fax to (877) 371-5712, by email to nursingcompliance@sos.ga.gov, or by mail to:

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

Treatment: By taking the step to self-report, it is likely that you have entered or recently completed a treatment program.

1) All nurses are expected to fully comply with the recommendations and treatment plan of that treatment provider to include practice restrictions/limitations.
2) It is strongly recommended to receive treatment at a facility that staffs a physician who is certified in addiction medicine. (The Board may require that you undergo a subsequent mental/physical examination if a physician who is certified in addiction medicine is not participating in your treatment.)
3) Complete and sign the Consent to Release Records form and have it notarized. Provide the Consent to Release form to your treatment provider so that they may release your records to the Board. 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.
4) If you are currently in treatment, have the treatment provider submit an admissions assessment, a treatment plan, and an estimated discharge date, along with the Authentication of Records form.
5) If you have completed treatment, have the treatment provider submit a discharge summary that includes the following: (1) type of treatment completed with admission and discharge dates; (2) diagnoses and medications; (3) drug screenings; (4) any continued treatment plans recommended; (5) a statement from the treating physician stating whether you are safe to practice nursing with reasonable skill and safety and/or whether there should be any practice limitations; and (6) Authentication of Records form.

It is very important that we receive this information as soon as you are discharged from treatment. If the Board does not receive all of this information timely, including the safe to practice statement, the Board may require that you undergo a subsequent mental/physical examination.

Board Rule 410-01-.03 requires nurses to notify the Board of any address/email changes. Address/email changes may be completed on the Board's website at www.sos.ga.gov/plb/nursing under "Online Services."

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 not work if you are impaired by alcohol, drugs, narcotics, chemicals, or a mental or physical condition. You must let your employer or potential employer know that your ability to work is under review by the Board.

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Self Report Form

Last Name:	First Name:	
Middle Name:	Previous Name(s):	
Georgia License Number:		
Email:		
Mailing Address:		
City:	State:	Zip
Phone:	Alternate Phone:	

Please note, Board Rule 410-1-.03(2) requires licensees to notify the Board in writing within thirty (30) days of any mailing, physical or email address changes.

Self-Report Information

Please list the name(s) of substance(s) abused:

Please check all of the following that apply to you:

❒ Prescription Fraud/Forgery ❒ Diversion From Patients/Workplace ❒ Abuse/misuse of Prescription Drugs

❒ Abuse of Alcohol ❒ Drug Seeking Through Physicians/Practitioners

❒ Abuse of Illicit Substances/Illegal Drugs

❒ Other (Please explain):_____

_____

_____

Where did the incident occur (Please provide full address)?_____

_____

Date incident occurred?

Employment Information

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

If yes, please provide the contact information for the Director of Nursing or nursing supervisor below.

Director of Nursing/Nursing Supervisor:

Facility Name:

Mailing Address:

City:	State:	Zip
Phone:	Email:	

Were you terminated as a result of your impairment? ❒ No ❒ Yes

If no, was any disciplinary action or other action taken against you following the incident? ❒ No ❒ Yes

Did you work while impaired? ❒ No ❒ Yes

Are you currently working as a nurse or in another healthcare field? ❒ No ❒ Yes

If yes, please enter your employer's contact information below.

Director of Nursing/Nursing Supervisor:

Facility Name:

Mailing Address:

City:	State:	Zip
Phone:	Email:	

Legal Information

Were you arrested or charged with a crime because of your impairment? ❒ No ❒ Yes

If yes, please list the charges:_____

_____

Please list the county and state where you were charged:_____

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

Treatment Information

Did you enter treatment? ❒ No ❒ Yes

If yes, please list the treatment facility and physician below.

If you have not sought treatment you are encouraged to do so immediately!

Facility Name:		
Treating Physician:		
Mailing Address:		
City:	State:	Zip
Phone:	Email:	
Date Entered Treatment:	Estimated Completion Date:	

You must have your treatment provider submit certified copies of your treatment records to the Georgia Board of Nursing. Please see the first page of the self-report packet for detailed information regarding the documentation that must be included with your treatment records. Documentation should be submitted to the Board within two weeks of your discharge from the treatment facility.

By signing this document, you agree to:
1) Notify the Board in writing of any change in your employment status;
2) Inform any current or prospective nursing employers that your ability to practice nursing is under review by the Board;
3) Authorize the Board and/or its designee to contact any past, current or prospective employer 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 nursing while impaired.

_____ _____

Printed Name of Licensee Date

_____

Licensee Signature

Please send the completed and signed form immediately to:

Georgia Board of Nursing
237 Coliseum Drive, Macon, Georgia 31217-3858
Telephone 844-753-7825 Select Option One
Fax: (877) 371-5712
nursingcompliance@sos.ga.gov
www.sos.ga.gov/plb/nursing

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Authentication of Records

Before me, the undersigned, personally appeared:

Name:	Title:

And certifies that he/she is of sound mind, is capable of making this affidavit and that he/she is a custodian of business/medical records who is the person responsible for the keeping of these records for:

Name of Entity:

Division/Department In Which Records Are Kept:

Mailing Address:

City:	State:	Zip

Phone:	Email:

The undersigned also certifies that the herein attached records are _____pages (number of pages, attached including the certification) of true and accurate reproductions and copies of business/medical records concerning (name, date of birth, last four digits of social security number):

Name:

Date of Birth:	Last Four Digits of SSN:

These records are kept by:

Name:	Title:

And were:
A) Made at or near the time of the described acts, events, conditions, opinions or diagnoses;
B) Made by, or from information transmitted by a person with personal knowledge and a business duty to report;
C) Kept in the course of a regularly conducted business activity; and,
D) It was the regular practice of that business activity to make the memorandum, report, record or data compilation.

The records attached hereto are the original or exact duplicates of the original documents. The undersigned further certifies that said records with this attached certificate were delivered to:

_____

For: _____

Who sought production of these documents pursuant to a subpoena and/or by written request.

Custodian of Records Signature:
Custodian of Records Printed Name:
Sworn to and subscribed before me this _____ day of _____, 20_____. _____ _____ Signature of Notary Public Commission Expiration Date **- THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY -**

Georgia
Board Of Nursing

Consent to Release Records

To: _____

_____

_____
(Please List Facility Name Where Examination Was Performed)

I, _____, do hereby consent to and authorize the release of any and all records, including alcohol and drug treatment and psychiatric records, concerning any examination performed pursuant to the terms of this Order, or 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 (Board) or a designee thereof. I understand that this disclosure is for use by the Board in its investigation concerning my fitness to practice as a registered professional or licensed practical nurse in the State of Georgia, pursuant to O.C.G.A. § 43-26 and 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.

_____ _____
Printed Name of Licensee Date

_____
Licensee Signature

Sworn to and subscribed before me this _____ day of _____, 20_____.

_____ _____
Signature of Notary Public Commission Expiration Date

- THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY -