NC Board of Nursing (NCBON) Sobriety Notebook

Licensee Name: _____

☐ RN ☐ LPN License Number _____

Contents

Email the Regulatory Compliance Coordinator if:

- Any information changes following submission of the Notebook.
- You are on court probation.
- You owe an outstanding fee to the NCBON, but no invoice is available within the Nurse Gateway (**All outstanding fees must be paid in full prior to reinstatement*).

Getting Started

Once you have communicated with and received a response from a Regulatory Compliance Coordinator (Coordinator), continue to communicate with him/her regarding the Notebook:

☐ Candy Elliott candace@ncbon.com **OR** ☐ Jess Castro jcastro@ncbon.com

Read the Sobriety Notebook (Notebook), in full: Successful submission of the Notebook includes 12 months of continuous drug screening with FSSolutions, 12 months of 12-step meeting attendance, a minimum of 6 months of aftercare, evaluation by a NCBON participating addictionologist and additional documentation.

Update Contact Information: Log into the Nurse Gateway to verify your contact information is up to date (address, email, telephone numbers) at the following link: https://portal.ncbon.com/index.aspx

Submission of Completed Notebook: Submit completed Notebook via parcel service in a binder with numerated tabs to correlate documents with the table of contents (Items 1-14).

DO NOT PLACE PAGES IN PROTECTIVE SLEEVES

Attn: Regulatory Compliance Coordinator – CDDP

PO Box 2129
Raleigh, NC 27602

4516 Lake Boone Trail
Raleigh, NC 27607

Your Notebook will be reviewed within 1 month of receipt.

- **If complete**, a Consent Order will be sent to you via e-mail.
- **If incomplete**, the Notebook will be returned to you with instructions for resubmitting with evidence of full compliance for a specified period of time. A Notebook may be returned for reasons including but not limited to:
    - Non-compliance with FSSolutions in the 12 months preceding submission
        - Failed drug screen(s)
        - ≥ 11 missed check-ins
        - > 1 failure to screen when selected
    - Non-compliance with12-step meeting / treatment attendance
    - Failure to provide requested documentation

Reinstatement Application: If your NC nursing license has expired, you will be directed to complete a reinstatement application in your Nurse Gateway once your Notebook review is completed. The fee is $180.00.

Refresher Course / Continuing Competence: In accordance with the NC Nursing Practice Act, 90-171.35, if you have been without a nursing license for 5+ years, you will be required to complete an NCBON approved Refresher Course. **You may not begin any portion of the course until a Consent Order is executed authorizing you to do so.** If you do not reside in NC, you may be required to return to NC to complete a Board approved Refresher Course if one cannot be coordinated where you reside. It is your responsibility to reach out to the Board of Nursing in your jurisdiction of residence to inquire about the process to complete the refresher course under any conditions NC may specify. www.ncbon.com/licensure-listing-refresher-course

If you are not required to complete a Refresher Course, review the NCBON Continuing Competence requirements to ensure you are compliant. Maintain copies of the certificates of completion to produce if requested. **Do not provide copies with the Notebook.** https://www.ncbon.com/licensure-listing-continuing-competence

Item 1: Personal Information

Licensee Name: _____

Telephone: _____ Email: _____

☐ RN ☐ LPN License Number _____
Date of Surrender / Suspension of license: _____

APRN (check only if applies) ☐ NP ☐ CRNA ☐ CNM APRN Number _____

Describe the events leading to the suspension / surrender of your license and your request for reinstatement: _____
_____
_____
_____

The statements and documents in this Notebook are true in every respect. I have not suppressed any information that would affect the NCBON's consideration my application for reinstatement. I understand that failure to update my contact information in the Nurse Gateway and submit requested information will result in a delay in processing.

_____ _____
Licensee Signature Date

Last date of any substance use (drugs and alcohol): _____

Substance(s) of Choice: 1. _____
2. _____
3. _____

Method of Obtaining Substance(s) of Choice	
Street Purchase	No □ Yes □
Prescription Abuse	No □ Yes □
Fraudulently Obtaining Prescription	No □ Yes □ **If Yes**, specify your method of obtaining
Diversion	No □ Yes □ **If Yes**, specify your method of obtaining
Other	No □ Yes □ **If Yes**, specify

Item 2: Substance Use Disorder Treatment

Following the suspension of your NC license, list all substance use disorder treatment attended.			
Dates Enrolled, Discharged	**Diagnosis**	**Treatment type (Inpatient, IOP, Aftercare)**	**Facility (Include City, State)**

Required Substance Use Disorder treatment

Following the most recent relapse, a minimum of 6 months of weekly aftercare (once weekly individual or group sessions focusing on recovery) must be completed prior to submission of the Notebook. You are required to continue aftercare until you successfully complete a minimum of 1 year.

A signed, dated letter from your counselor to the attention of the Coordinator on facility letterhead is required to verify your compliance with aftercare, to include the following:

- Counselor name and telephone number
- Diagnosis
- Prognosis
- Attendance
  - Date you began weekly aftercare
  - Dates, reasons and plans to make up missed sessions
  - Verification of the number of aftercare sessions you have attended (a minimum of 6 months / 26 sessions are required at the time the Notebook is submitted)
- Verification of the following:
  - compliance with any other treatment recommendations
  - awareness of the reason for the suspension / surrender of your license
  - counselor is not related to you

Item 3: Addictionologist Evaluation

Attend the evaluation approximately 2 months prior to submission of the Notebook to assess your fitness to return to nursing practice. Failure follow the instructions below may result in a requirement to reschedule your evaluation and delay the review of your Notebook.

Scheduling the required addictionologist evaluation

1. Following 9 months of compliance with drug screening and 12-step meeting attendance, email the Coordinator to request a current list of participating addictionologists and Release of Information Authorization.

   Out of State Residents: If approved by the Coordinator, you may be evaluated by an addictionologist in another jurisdiction. To request approval, provide a copy of the addictionologist's curriculum vitae and board certification credentials verifying he/she is a member of one of the following are due for review:

   - American Society of Addictions Medicine (ASAM)
   - American Board of Addictions Medicine (ABAM) **or**
   - American Psychiatric association (APA) **and** is certified in addictions medicine

2. **2 weeks prior to the appointment,** email the Coordinator a .pdf copy of the completed Release of Information Authorization.
3. Sign a release of information with the addictionologist to discuss your case with NCBON staff and provide a copy of the evaluation to the NCBON.
4. Submit evidence of compliance with all recommendations made by the addictionologist.

Evidence of compliance with addictionologist recommendations

Evaluating Addictionologist: _____ Date: _____

Addictionologist Recommendation	Evidence of Compliance with Recommendation
1.	
2.	
3.	
4.	

Item 4: 12-Step Participation
Alcoholics Anonymous (AA) / Narcotics Anonymous (NA)

1. **Use the AA/NA Attendance Verification Form to document attendance at a minimum of 3 12-step meetings each week for the 12 months directly preceding submission of the Notebook. Continue meeting attendance following submission of the Notebook.**

Date Initiated Attendance at 12-step meetings	Date:
Do you have a home group?	No □ Yes □ **If Yes**, specify name and meeting location
Sponsor Information	First name: How long have you worked with this sponsor: Frequency of telephone / text contact: Frequency of step work meetings:
Step Work	What step are you presently working? Have you completed the 12 steps?
What impact has your engagement in the 12-step program had on your recovery?	

2. **A letter from your 12-step sponsor is required, to include the following. Do not compose the letter for your sponsor.**
   - Addressed to the Coordinator
   - Verification of:
     - The duration of your sponsor-sponsee relationship
     - Your engagement in the 12-step program (specify AA or NA)
     - Frequency of contact, including telephone / text and in-person step work meetings
     - The current step you are working
     - Verification that you are not related to the sponsor
     - Sponsor's
       - Length of sobriety
       - Signature (first name)
       - Telephone number for NCBON staff to contact

AA/NA Attendance Verification* for _____
Licensee Name

Attendance at a minimum of 3 12-step meetings each week for the 12 months directly preceding submission of the Notebook is required.			
Date Attended	**Meeting Name**	**Meeting Location (Building, City & State)**	**Meeting Chair Signature**

Copy this form as necessary

Item 5: Current Medications

For the duration of the Notebook, file all prescriptions with FSSolutions on the Prescriber Verified Prescription Identification Form (Rx ID form). Include copies of all Rx ID forms with the Notebook.

List all currently prescribed and current over-the-counter medications (including herbal supplements). If none, write "N/A."						
Medication	**Dose**	**Frequency**	**Diagnosis**	**Prescriber Name**	**Date Initiated**	**Expected Duration**

Item 6: Current Healthcare Providers

List your current healthcare providers. Specify a primary care provider. If none, please write "N/A."

***If you do not have a primary care provider, attach a statement explaining the reason and your action plan, should you have a healthcare event requiring evaluation.**

Provider Name and Credential (MD, DO, NP, PA, etc.)	Practice Name	Practice Address	Practice Telephone	Date Established as Patient
Primary Care* Provider:				
Dentist:				
Other: **Specialty:**				
Other: **Specialty:**				
Other: **Specialty:**				

1. **Submit a signed, dated letter to the attention of the Coordinator from each provider listed above on practice letterhead to include:**
   - Awareness of
     - Your substance use disorder diagnosis
     - Your substance(s) of choice
     - Your sobriety date
     - The status of your NC nursing license
     - All prescriptions received from other providers
   - Verification of
     - Diagnoses treated by the provider
     - Medications prescribed including dosage, frequency, plans to continue
     - You are not related to or employed by the provider

2. **Have you been hospitalized, treated in an emergency department, urgent care or undergone surgery (inpatient or outpatient) in the past year?**

   ☐ **No** ☐ **Yes** **If Yes, provide treatment summaries.**

3. **Are you presently participating in a Pain Management Agreement?**

   ☐ **No** ☐ **Yes** **If Yes, include a copy of the agreement.**

4. **Are you presently prescribed Naltrexone, Buprenorphine or Methadone?**

   ☐ **No** ☐ **Yes**

   If Yes, provide a copy of your Medication Assisted Treatment Program Contract.

Item 7: List of Professional Licenses / Certifications

Include **all** professional licenses / certifications, in any jurisdiction including, but not limited to medication aide, nurse aide, paramedic, dental hygienist, chiropractor, attorney, advance practice, etc.		
Jurisdiction	**Year Licensed**	**Current Status**
North Carolina License / Certification Type: License / Certification Number:		☐ Current, unencumbered ☐ Expired / Lapsed, unencumbered ☐ Suspended* ☐ Other discipline / encumbrance (specify)* ____________________________
Jurisdiction: License / Certification Type: License / Certification Number:		☐ Current, unencumbered ☐ Expired / Lapsed, unencumbered ☐ Suspended* ☐ Other discipline / encumbrance (specify)* ____________________________
Jurisdiction: License / Certification Type: License / Certification Number:		☐ Current, unencumbered ☐ Expired / Lapsed, unencumbered ☐ Suspended* ☐ Other discipline / encumbrance (specify)* ____________________________
Jurisdiction: License / Certification Type: License / Certification Number:		☐ Current, unencumbered ☐ Expired / Lapsed, unencumbered ☐ Suspended* ☐ Other discipline / encumbrance (specify)* ____________________________

Copy this form as necessary

Item 8: Conviction History

Are you currently on court ordered probation?

☐ Yes ☐ No

Have you been convicted of or do you have pending any of the following (check all that apply and provide dates):			
	***Pending**	***Previous conviction(s)**	**Never charged or convicted**
Driving While Impaired / Driving Under the Influence	☐	☐	☐
Misdemeanor	☐	☐	☐
Felony	☐	☐	☐

***If you have a criminal record or pending charges** email the Coordinator a summary of your conviction(s) / charge(s) to determine if the matter is already on file. If not on file, you will be required to submit a certified record and explanation.

Item 9: Criminal Background Check (CBC)

If your license has been suspended/lapsed/inactive/surrendered/held in abeyance for 6 months or more, you must submit to a CBC prior to reinstatement of the license. The CBC is valid for 1 year.

North Carolina Residents:
The application and instructions for the CBC Check Livescan Application are available in the Licensure and Listing section of the NCBON website: https://www.ncbon.com/licensure-listing-criminal-background-check-live-scan

You must be fingerprinted at a Sheriff or Police Department in North Carolina that can process electronic transmittals directly to the SBI/FBI.

Out-of-State Residents:
If you reside in another state or country, email the Licensure Coordinator at kbridges@ncbon.com your name and mailing address to request the materials required to complete the CBC. Fingerprinting must be performed by trained law enforcement personnel. Contact your local sheriff or police office for assistance and additional details.

Submit the CBC 2 months prior to the date you plan to submit your Notebook. It may take 4 to 8 weeks from the date submitted for the CBC results to be returned to the NCBON. Your Notebook will be incomplete until the results of the CBC are received in the NCBON.

Item 10: Employment History

Provide a current resume to include the following:

- Degrees held – include date awarded, educational institution and City, State
- Professional certifications held – include jurisdiction, certification / license type, number, expiration date and present status
- For all employments (nursing and non-nursing) for the last 5 years:
    - Position title
    - Dates of employment
    - Employer name
    - City, State
    - If you have left an employment, indicate the reason and whether or not you are eligible for rehire (if you are not, specify the reason)

Item 11: Reference Letters:

Provide reference letters as outlined. Do not compose the letters for your references to sign.

1. Submit a maximum of 3 dated letters written and signed by non-family members in sealed envelopes with your Notebook. The references should be aware of the suspension / surrender of your NC nursing license, conviction history (if applicable) and include a working telephone number. If you are not currently employed, ensure one of the letters is from a professional reference.

2. If you are currently employed, provide a dated letter written and signed by your current supervisor to the attention of the NCBON Regulatory Compliance Coordinator on letterhead confirming your title, responsibilities and work performance. If the employment is healthcare related, include a copy of the position description.

Item 12: Relapse Prevention Plan

Submit a typed relapse prevention plan to include the following:

- Insights into the events that brought you to the attention of the NCBON and impact on patient care and coworkers
- What motivates you to maintain your sobriety?
- Describe your support system
- Identify triggers and high-risk situations
- What activities are you engaged in to support your sobriety (self-care to support emotional, mental and physical health)?
- Related to your return to nursing practice:
    - Identify concerns about potential work settings and impact on your recovery
    - Describe desired areas of practice and potential employment settings
    - Identify how you plan to maintain your recovery program once you return to practice

Item 13: Compliance with Random Body Fluid Screening

Provide evidence of a minimum of 12 months of continuous successful observed random body fluid screening with FSSolutions, the drug screening company for the NCBON.

Following registration, you will receive an Enrollment Package from FSSolutions. Read the Enrollment Package in full to ensure you are compliant with all drug screening requirements. The Enrollment Package provides additional guidelines related to drug screening, including a Prescriber Verified Prescription Identification Form, due to FSSolutions within 5 days of any prescription received (regardless of whether the medication was filled, consumed or wasted).

Successful random body fluid screening is defined as:

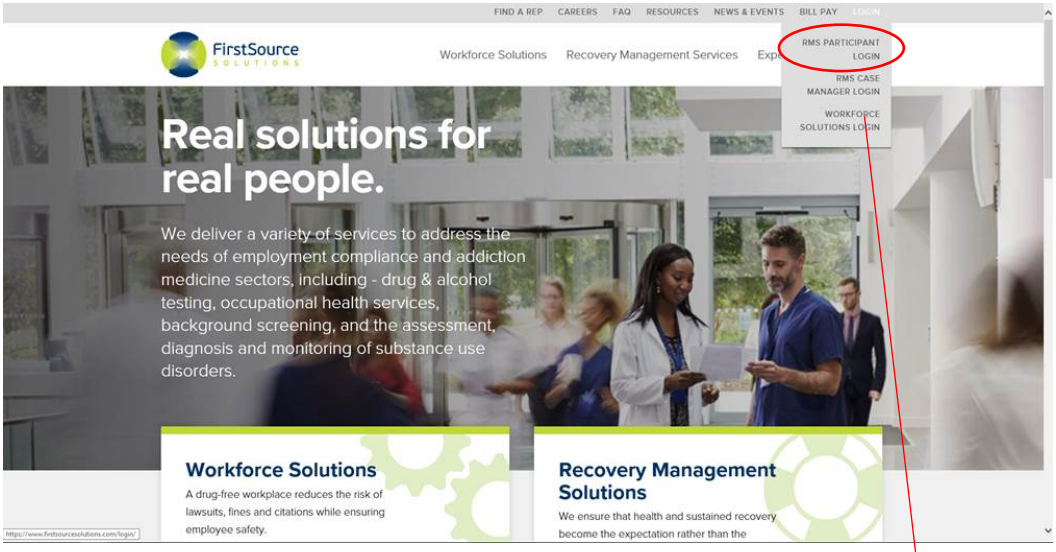
1. Abstinence from mood altering chemicals and alcohol.
2. Checking into FSSolutions each weekday and screening as selected.
3. Ensuring you always have Chain of Custody Forms (COCs) in your possession, in the event you are selected to drug screen. If you need additional COCs, contact FSSolutions.
4. Maintaining an active account with FSSolutions.
5. Filing the following with FSSolutions within five 5 days*:
    a. Prescriber Verified Prescription Identification Forms
    b. Urgent care treatment records
    c. Emergency department treatment records
    d. Hospital admission and discharge summaries
6. Submission of specimens that are not dilute and not failed by the Medical Review Officer (MRO).
7. Notifying FSSolutions of your travel plans and coordinating collection sites in your destination.

**** For the duration of the Notebook, only file with FSSolutions and maintain a copy to submit with the Notebook. Once you have entered into a Published Consent Order, you will be required to file this documentation with FSSolutions and the NCBON.***

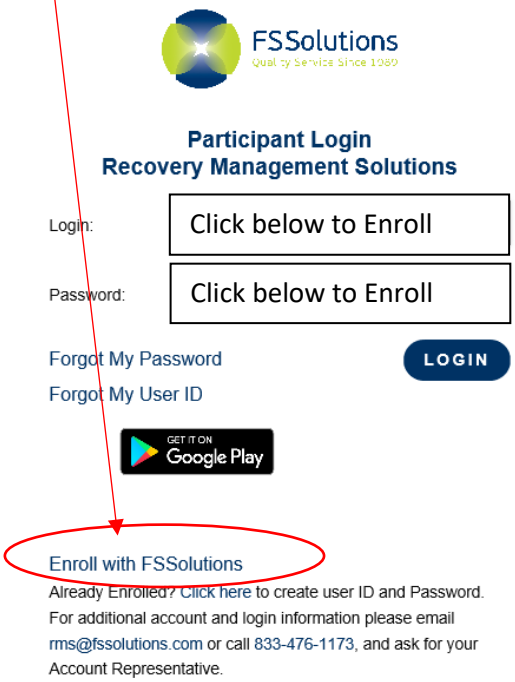
FSSolutions Enrollment Instructions

Please follow the instructions outlined below to register with FSSolutions.

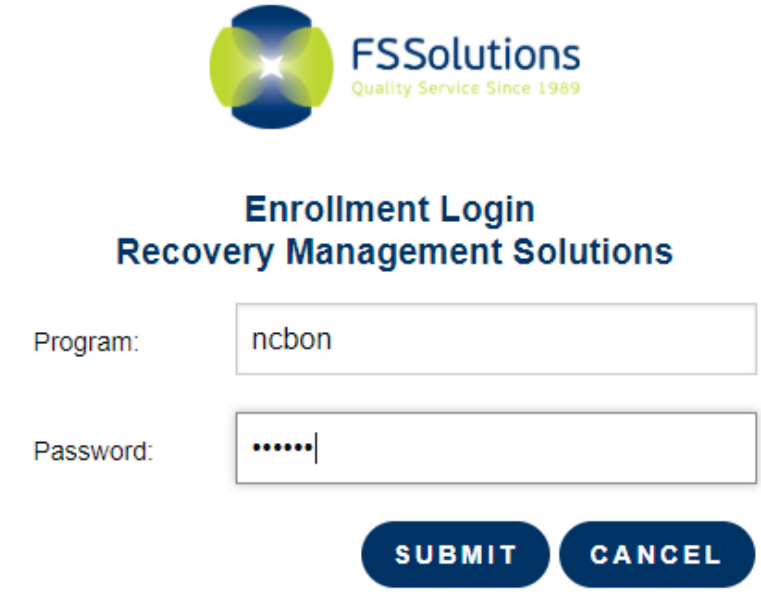
1. Go to www.fssolutions.com.
   - Note: Please do not use a mobile phone device. A desktop or laptop should be used for enrollment as you will need to read and print the agreement.
2. Click on the "**LOGIN**" drop down in top right corner.
3. Click on "**RMS Participant Login"**



4. Click on "**Enroll with FSSolutions**"
   - *Do not attempt log in until you have completed enrollment*



After clicking **"Enroll with FSSolutions"**, you will be brought to another page:



5. Enter your Program and Password:

Program: ncbon

Password: enroll

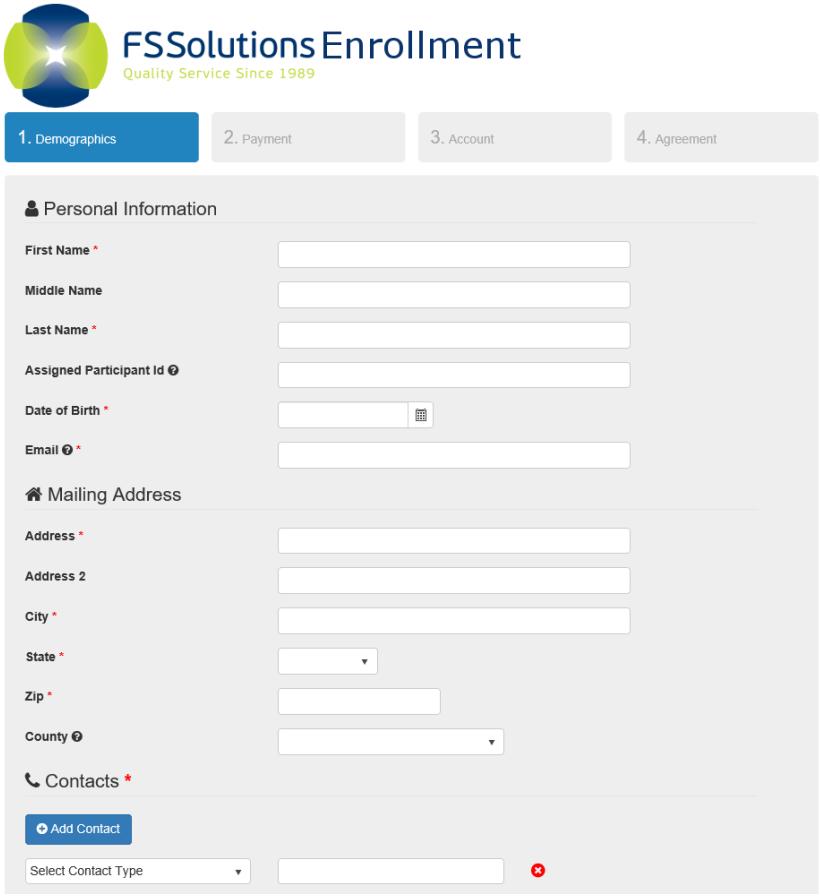
Begin your Enrollment:

7. Fill in all of the required fields indicated with an ***.**
8. **Fill in your Assigned Participant ID as:**

615-00-XXXX

(xxxx=last 4 of your SSN)

9. Read and electronically sign the Agreement. Then click "**Submit**".
10. Print and read the enrollment packet in its entirety.



***If you need assistance with Enrollment, contact Coleen Cooper with FSSolutions at 833-476-1173 x 5563 / ccooper@fssolutions.com.**

Item 14: Verification of Releases of Information

Sign releases with all providers releasing the provider to speak with NCBON staff regarding any and all diagnoses, treatments, medications, recommendations and outcomes. List the individuals and agencies with which you have current signed releases.

Provider Name and Credential (MD, DO, NP, PA, LCAS, LCSW etc.)	Facility Name	Facility Address	Facility Telephone	Date Release Signed
Primary Care* Provider:				
Dentist:				
Other:				
Other:				
Other:				
Other:				
Other:				