Case Analyst: _____

NCBON North Carolina Board of Nursing

P.O. Box 2129 | Raleigh, NC 27602 | P: 919.782.3211 | F: 919.781.9461 | ncbon.com

NCBON 6 Months Sobriety Notebook

If you are reviewing this Notebook following the 2nd or subsequent suspension of the license or if you have been convicted of a Felony following the suspension of the license, email the Director of Compliance abailey@ncbon.com to request an appearance before the Licensure Review Panel and applicable Sobriety Notebook.

Licensee Name: _____

☐ RN ☐ LPN License Number _____

Contents

Email the Compliance Case Analyst 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 Portal (**All outstanding fees must be paid in full prior to reinstatement*).

Getting Started

Once you have communicated with a Compliance Case Analyst (Case Analyst), continue to communicate with them regarding the Sobriety Notebook:

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

Read the Sobriety Notebook (Notebook), in full: You are eligible to request reinstatement following the 1st suspension of the license for the timeframe specified in the Order to Suspend **and** by submitting the completed Notebook evidencing 6 months of sobriety.

Successful submission of the Notebook includes 6 months of continuous drug screening evidencing abstinence from all mood-altering substances (including alcohol) with Vault Workforce Screening (Vault), NCBON approved structured mutual support group meeting attendance, a minimum of 6 months of aftercare, evaluation by a NCBON participating addictionologist and additional documentation.

Verify Contact Information: Log into the Nurse Portal to verify your contact information: https://portal.ncbon.com/index.aspx

Refresher Course / Continuing Competence: In accordance with the NC Nursing Practice Act, 90-171.35, if you have been without a nursing license in any jurisdiction for a period of greater than 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 NCBON 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/rn-lpn-continuing-compentence

Application and Criminal Background Check (CBC)

When you are notifying the NCBON of your scheduled addictionologist evaluation (Item 3), the reinstatement application and CBC will be made available to you in the Nurse Portal.

- If your NC nursing license has expired, you are required to complete a reinstatement application in the Nurse Portal – the fee is $180.00.
- All applicants are required to submit an updated CBC
  - NC Residents: The application and instructions for the Livescan CBC are available in the Nurse Portal. You must be fingerprinted at a sheriff or police department in NC that can process electronic transmittals directly to the SBI/FBI.
  - Out of State Residents: The application and instructions for the CBC are available in the Nurse Portal. You will need to obtain a fingerprint card and be fingerprinted at your local law enforcement agency, as Livescan is not available outside of NC.
  - CBC results are valid for 1 year.

Submission of Completed Notebook:

Apply for reinstatement, complete the CBC and submit the completed Notebook via parcel service in a binder with numerated tabs to correlate documents with the table of contents (Items 1-13). Your Notebook will be reviewed within 1 month of receipt.

DO NOT PLACE PAGES IN PROTECTIVE SLEEVES

Attn: Compliance Case Analyst – DP

PO Box 2129
Raleigh, NC 27602

4516 Lake Boone Trail
Raleigh, NC 27607

If complete, a Consent Order for participation in the Discipline Program for Nurses in Recovery (DP) will be sent to you via e-mail. Terms of the DP include:

- Monitoring for 3 years of satisfactory employment in a licensed nursing position while satisfying all other conditions or after 5 years of non-failed drug screening
- Continued random, observed drug testing
- Continued attendance at approved structured mutual support group meetings
- Completion of treatment
- NCBON approval required for all nursing employment, employment conditions, employer awareness of participation and quarterly Work Performance Evaluations from clinical RN supervisor

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 Vault in the 6 months preceding submission
  - Failed drug screen(s)
  - Missed check ins - $\geq$ 11, multiple instances of consecutive missed check-ins and failing to check in > 3 days consecutively
  - > 1 failure to screen when selected
- Non-compliance with NCBON approved structured mutual support group meeting / treatment attendance
- Failure to provide requested documentation

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 Portal 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)**

Substance Use Disorder treatment required prior to submission of the Notebook
Following the most recent failed, positive drug screen or relapse, a minimum of 6 months of weekly aftercare (once weekly individual or group sessions focusing on recovery) must be completed. Continue aftercare until you successfully complete a minimum of 1 year.

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

- A copy of the assessment and treatment plan
- 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 to 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. Email the Case Analyst to request a current list of participating addictionologists and Release of Information Authorization following compliance with drug screening, NCBON approved structured mutual support group meeting attendance and aftercare for **3 months**.
   Out of State Residents: If approved by the Case Analyst, 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 Case Analyst 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: Approved Mutual Support Group Meeting Attendance

Use the NCBON Approved Structured Mutual Support Group Meeting Log to document attendance at a minimum of 3 approved mutual support group meetings each week for the 6 months directly preceding submission of the Notebook. Continue meeting attendance following submission of the Notebook. Copy log as necessary.

Date attendance initiated	
How has your engagement in approved structured mutual support group meetings impacted your recovery?	

NCBON Approved Structured Mutual Support Group Meetings		
Organization	**Website**	**In person / Virtual**
Alcoholics Anonymous	www.aa.org	Both
Celebrate Recovery	www.celebraterecovery.com	Both
Drug Addicts Anonymous	https://daausa.org	In person
International Doctors in Alcoholics Anonymous	https://www.idaa.org	Both
LifeRing Secular Recovery	https://lifering.org	Both
Marijuana Anonymous	https://marijuana-anonyomous.org	Both (**Phone meetings **not approved** to satisfy minimum 3 meetings weekly)*
Narcotics Anonymous	https://na.org	Both
Recovery Dharma	https://recoverydharma.org	Both
Refuge Recovery	https://refugerecovery.org	Both
Secular Organizations for Sobriety	https://sossobriety.org	Both
Self-Management and Recovery Training - SMART Recovery	www.smartrecovery.org	Both
Women for Sobriety	https://womenforsobriety.org	In-person, Asheville (**Online forum **not approved** to satisfy minimum 3 meetings weekly)*

NC Board of Nursing Sobriety Notebook
Approved Mutual Structured Support Group Meeting Log
Applicant: _____

Date	Approved Structured Mutual Support Group	Meeting Name	Meeting Format In person = IP Virtual = V
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
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35.			
36.			
37.			
38.			
39.			

Item 5: Current Medications

For the duration of the Notebook, file all prescriptions in the Vault Participant Portal by submitting the Healthcare Provider Verification Form, pharmacy prescription tag and, if requested, pharmacy reports. Submit copies of all forms with the completed Notebook.

List all currently prescribed and current over-the-counter medications (including herbal supplements). If none, write "N/A."

Ensure all prescriptions are up to date and on file with Vault.

Medication	Dose	Frequency	Diagnosis	Prescriber Name	Date Initiated	Expected Duration

Item 6: Current Healthcare Providers

For the duration of the Notebook, file all providers in the Vault Participant Portal by submitting the Healthcare Provider Verification Form within 5 days of establishing with a new provider.

List your current health care providers. 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. **Ensure a Healthcare Provider Verification Form is on file with the NCBON and Vault for all current healthcare providers.**

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 Case Analyst 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: 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 10: 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 11: Compliance with Random Body Fluid Screening

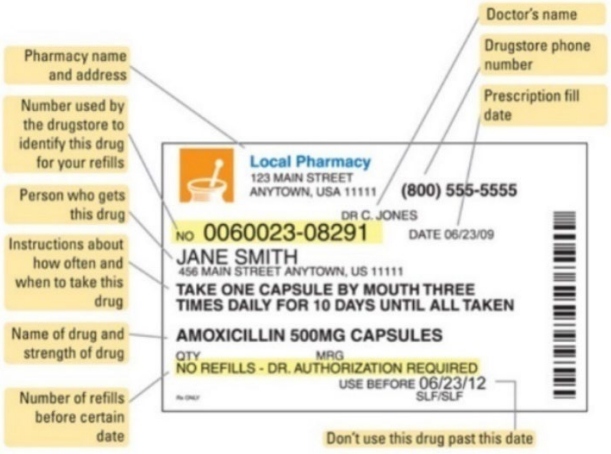
Provide evidence of a minimum of 6 months of continuous successful random observed drug screens (to include but not limited to urine, blood, hair, body fluids, breathalyzer, nails) as requested by Vault, the drug screening company for the NCBON following a chain of custody (CCF) protocol.

Following registration, review all documents in the Vault Portal under "Actions, Download Documents."

Successful random body fluid screening is defined as:

1. Abstinence from products and substances that may result in a positive drug screen.
2. Checking into Vault weekday between 5am and 3pm EST and screening as selected.
3. Ensure you have 2 CCFs on hand at all times. Request additional in the Vault Portal under "Action, Order CCFs."
4. Maintaining an active account with Vault.
5. Filing the following in the Vault Participant Portal:
    a. Completed Healthcare Provider Verification Forms are due from all healthcare providers:
        i. Within 10 days of beginning drug screening
        ii. On an ongoing basis within 5 days of establishing with a new provider
    b. Pharmacy prescription tags* within 5 days of filling any prescription
    c. Pharmacy reports as requested
    d. Urgent care treatment records
    e. Emergency department treatment records
    f. Hospital admission and discharge summaries
6. Submission of specimens that are not dilute and not failed by the Medical Review Officer (MRO).
7. Notifying Vault of your travel plans and coordinating collection sites in your destination.

**Do not upload photos of pill bottles. Pharmacy prescription tag example:*



Case Analyst: _____

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HEALTHCARE PROVIDER VERIFICATION FORM

_____ is drug screening for the NCBON.
Licensee Name

Please complete this form to verify medications you are presently prescribing (including samples and injections administered in office) and your awareness that Licensee is actively monitored under a Consent Order with the NCBON or seeking reinstatement following suspension related to the following substances:

1. _____
2. _____
3. _____
4. _____

Licensee is responsible for:

- Submitting random, observed drug screens as selected by Vault Workforce Screening, the drug screening agency for the NCBON.
- Attending treatment and mutual support group meetings, if diagnosed with a Substance Use Disorder.
- Uploading to the Vault Workforce Screening Participant Portal:
  - completed Healthcare Provider Verification Forms
    - from all providers within 10 days of entry into Consent Order
    - on an ongoing basis within 5 days of establishing with new provider
  - pharmacy prescription receipts within 5 days of filling any prescription
  - pharmacy reports as requested
- Notifying the NCBON of any new healthcare provider relationship

☐ I am not presently prescribing any medications to Licensee.

Prescription Date	Medication	Quantity Prescribed	Is prescription PRN?	Expected Treatment Duration
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

_____
Provider Name (print)

_____
Provider Signature

Facility: _____

Date: _____

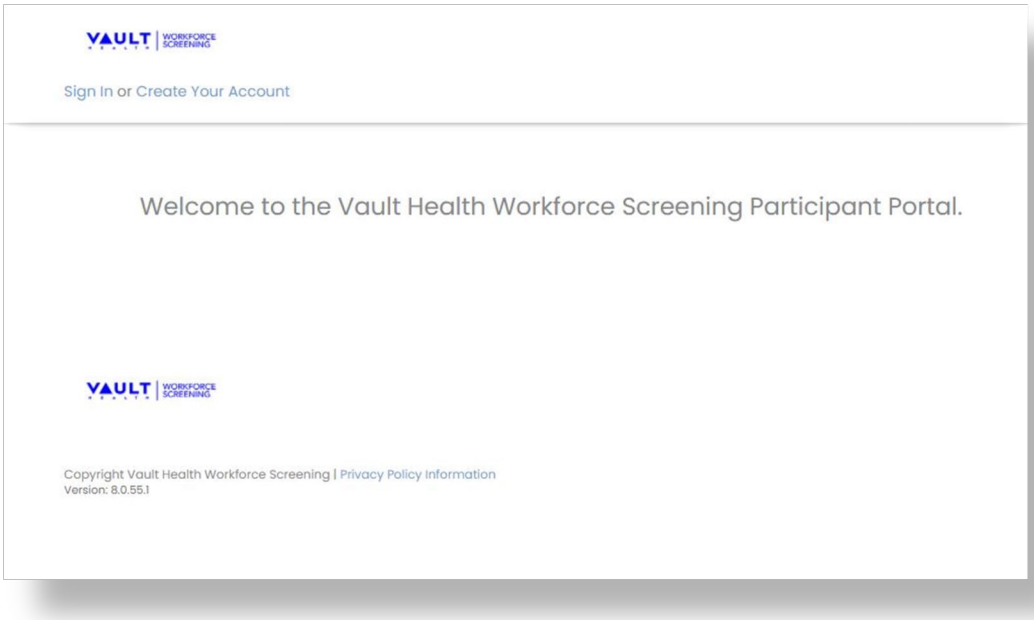
Address: _____
_____

Phone Number: _____
Email: _____

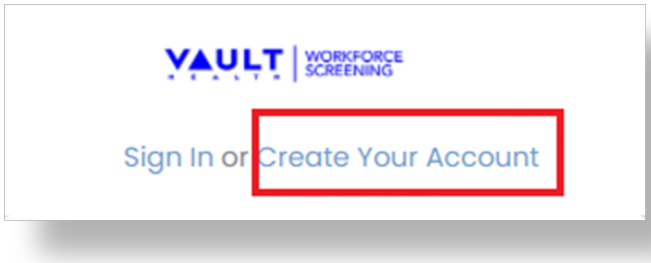
Enrollment in Drug Screening

1. Visit the URL [Vault Health Workforce Screening Participant Portal (caseworthy.com)](https://prod.caseworthy.com/CaseWorthy/PortalDefault.aspx?DatabaseID=890&#/PortalDefault)

   https://prod.caseworthy.com/CaseWorthy/PortalDefault.aspx?DatabaseID=890&#/PortalDefault



2. Click the “Create Your Account” link at the top of the page



3. Read and accept the terms and conditions on the page that appears.
4. Use the Program ID and PIN provided below to enroll: The program ID and Pin below, are a one-time use. You will be assigned a new participant ID after you have completed the enrollment.

Program ID	17525
PIN	72026

5. Confirm that NC Board of Nursing is selected as the Agency Name

6. Read and accept the terms and conditions on the page that appears.
7. Fill out your demographic information and choose a username. Your password will be set and provided at the end of enrollment.
8. Enter your credit card information.
9. Complete your enrollment.
10. You will receive an e-mail including confirmation of your enrollments and important information pertaining to your program and you're testing with Vault.
11. After you have successfully enrolled, please refresh the website and click the "Sign In" button and use your log in ID and temporary password to log in.
12. You may be prompted to change your password.
13. There is a blue "Click Here to Check In" button that you must select every day to get your testing message. Be sure to log out of your account following your daily check in or any portal activity.

Enrollment Troubleshooting

1. Do not google "Vault Workforce Screening." You must utilize the link above.

2. To save the Vault portal log in link to your mobile device as an icon/button, please click on the link below and follow the instructional links for either iPhone or Android: https://www.youtube.com/channel/UC97PUjpzSnnRhdamMNy7BcQ

3. If you receive an invalid user ID, please check you are on the correct link.

For any other issues with Enrollment or logging in, please call an RMS representative 833-476-1173 and inform them you need help accessing the participant portal.

Do not message the NCBON Case Analyst through the Participant Portal – contact directly via email or telephone.

Item 12: 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:				