

# North Carolina Board of Nursing One Year Sobriety Notebook

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**ITEM 1: Information about YOU.**

This document provides a summary and overview of your particular case. This item must be completed, signed and dated no more than five (5) days prior to submission for review. Do not leave any sections incomplete. If not applicable, mark "N/A."

Full Name: \_\_\_\_\_

Date Submitting Information: \_\_\_\_\_  
(Must be at least one (1) year from date of Surrender / Suspension of License).

Date of Surrender/Suspension of License: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_  
Work (\_\_\_\_) \_\_\_\_\_

RN #: \_\_\_\_\_ LPN #: \_\_\_\_\_

Have you completed a drug/alcohol rehabilitation program? Yes \_\_\_ No \_\_\_

Have you completed an Aftercare program which lasted one (1) year? Yes \_\_\_ No \_\_\_

Are you participating in a twelve-step program? Yes \_\_\_ No \_\_\_

If you have not participated in a twelve-step program, have you participated in an alternative program such as Women in Sobriety or Rational Recovery or any other program? Yes \_\_\_ No \_\_\_

Have you been participating in random drug screens through FIRSTLAB?  
Yes \_\_\_ No \_\_\_

Have you been evaluated by an Addictionologist in the last sixty days? Yes \_\_\_ No \_\_\_

Describe any current acute or chronic medical problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all current prescription and over-the-counter medications:

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Describe the incidents/ actions which have resulted in the loss of your license and your desire to seek reinstatement:

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Have you ever been in the North Carolina Board of Nursing Alternative Program for Chemical Dependency? Yes \_\_\_ No \_\_\_. If yes, what were the dates of participation, the reason for your participation and the outcome? \_\_\_\_\_

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Have you ever been in the North Carolina Board of Nursing Chemical Dependency Discipline Program? Yes \_\_\_ No \_\_\_. If yes, what were the dates of participation, the reason for your participation and the outcome? \_\_\_\_\_

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List your drugs of choice and abuse in order:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

How did you obtain your drugs when you were using?

Prescription abuse Yes \_\_\_ No \_\_\_  
Diversion Yes \_\_\_ No \_\_\_  
Street Purchase Yes \_\_\_ No \_\_\_  
Writing own Rx Yes \_\_\_ No \_\_\_  
Presenting illegal Rx Yes \_\_\_ No \_\_\_  
Other (explain) \_\_\_\_\_

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If you diverted, describe your method of diversion: \_\_\_\_\_

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Date of Sobriety: \_\_\_\_\_

Date last used/ abused drugs: \_\_\_\_\_ Date last drank alcohol: \_\_\_\_\_

Current Employer: \_\_\_\_\_

Do you have a criminal record? Yes \_\_\_ No \_\_\_

You are clean and sober now. How would someone know if you were using again?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything you wish to share that has not been asked? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The statements in this document and the items attached are true in every respect. I have not suppressed any information that would affect this application for review regarding reinstatement of my nursing license.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **ITEM 2: Resume**

Attach CURRENT resume to include the following from the beginning of your nursing career:

1. Any employment that you have held, specifying your position title and employing business
2. Beginning and ending dates of employment
3. Reason for leaving each employment
4. Statement as to whether or not you are eligible for rehire
5. Signed and dated no more than five (5) days prior to submission which indicates the resume is current.

**ITEM 3: Employment Since Surrender/Suspension of License**

If you have not been employed since you have been without your nursing license, sign the following statement:

***I have not been employed since I have been without my nursing license.***

\_\_\_\_\_  
Signature Date

- If, after you submit your packet of information, you become employed:
1. Call the Monitoring Coordinator (919-782-3211 ext. 283) and inform her.
  2. Submit the information in writing.

**List below, in chronological order, each employment that you have held since you have been without your nursing license.**

For each employment listed, have your direct supervisor write a letter to the CDDP Monitoring Coordinator. The letter must be composed by the supervisor and include the following:

- A telephone number where the supervisor may be contacted. If the supervisor is related to you in any manner, a statement identifying the relationship is required.
- The letter should address your work performance and duties.
- A statement from your supervisor regarding whether or not you are eligible for rehire.

1. Place \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Beginning date of employment: \_\_\_\_\_  
Ending date of employment: \_\_\_\_\_  
My job title: \_\_\_\_\_  
Supervisor: \_\_\_\_\_  
Phone Number of Supervisor: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

Eligible for rehire: Yes \_\_\_\_\_ No \_\_\_\_\_

If no, explain: \_\_\_\_\_

***If position is health care related, attach copy of position description.***

2. Place \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Beginning date of employment: \_\_\_\_\_  
Ending date of employment: \_\_\_\_\_  
My job title: \_\_\_\_\_  
Supervisor: \_\_\_\_\_  
Phone Number of Supervisor: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

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Eligible for rehire: Yes \_\_\_\_\_ No \_\_\_\_\_

If no, explain: \_\_\_\_\_

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***If position is health care related, attach copy of position description.***

3. Place \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Beginning date of employment: \_\_\_\_\_  
Ending date of employment: \_\_\_\_\_  
My job title: \_\_\_\_\_  
Supervisor: \_\_\_\_\_  
Phone Number of Supervisor: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

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Eligible for rehire: Yes \_\_\_\_\_ No \_\_\_\_\_

If no, explain: \_\_\_\_\_

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***If position is health care related, attach copy of position description.***

4. Place \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Beginning date of employment: \_\_\_\_\_  
Ending date of employment: \_\_\_\_\_  
My job title: \_\_\_\_\_  
Supervisor: \_\_\_\_\_  
Phone Number of Supervisor: \_\_\_\_\_  
Reason for leaving: \_\_\_\_\_

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Eligible for rehire: Yes \_\_\_\_\_ No \_\_\_\_\_

If no, explain: \_\_\_\_\_

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***If position is health care related, attach copy of position description.***

**ITEM 4: History of Treatments Received**

List below, in chronological order, all treatments ever received for substance abuse or related health conditions. **You must include all hospitalizations during the past year, regardless of the diagnosis.** For each treatment listed, submit the admission and discharge summary. If needed, add pages.

Begin with the most recent treatment:

1. Treatment facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
Admission Date: \_\_\_\_\_  
Discharge Date: \_\_\_\_\_  
Reason for Admission: \_\_\_\_\_  
\_\_\_\_\_  
Counselor: \_\_\_\_\_  
Did you successfully complete treatment? Yes \_\_\_ No \_\_\_, if no, explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
2. Treatment facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
Admission Date: \_\_\_\_\_  
Discharge Date: \_\_\_\_\_  
Reason for Admission: \_\_\_\_\_  
\_\_\_\_\_  
Counselor: \_\_\_\_\_  
Did you successfully complete treatment? Yes \_\_\_ No \_\_\_, if no, explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
3. Treatment facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
Admission Date: \_\_\_\_\_  
Discharge Date: \_\_\_\_\_  
Reason for Admission: \_\_\_\_\_  
\_\_\_\_\_  
Counselor: \_\_\_\_\_  
Did you successfully complete treatment? Yes \_\_\_ No \_\_\_, if no, explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **ITEM 5: Aftercare Participation**

**Aftercare Participation involves weekly individual or group sessions focusing on recovery.**

- **If your AP or CDDP Contract was terminated due to relapse and/or positive drug screen, you are required to complete a minimum of one (1) year of Aftercare beginning after your most recent relapse.** You must have completed a minimum of six (6) months of the one (1) year aftercare requirement at the time you submit the One Year Sobriety Notebook.
- If your contract was terminated for a reason **other than relapse or a positive drug screen**, it is understood you may have begun the one (1) year of attendance or even have completed the one (1) year of attendance prior to the surrender/ suspension of your license. However, if you have relapsed since your AP/CDDP contract was terminated, you must complete the required one (1) year of aftercare after your most recent relapse.
- Submit evidence of following your counselor's recommendations regarding aftercare if you have already completed one (1) year of attendance prior to the surrender/suspension of your license. You may be required to attend additional treatment or Aftercare depending on the recommendations of the Addictionologist or Counselor.

The following documentation regarding Aftercare is required from your counselor at your most recent treatment facility, on facility letterhead stationary:

1. Name and telephone number of the Counselor.
2. That you have discussed with him/her the reason for the surrender/suspension of your license.
3. Evidence of complying with any recommendations. Evidence that you have successfully begun and/or completed one (1) year of aftercare. You must have completed at least six (6) months of the required one (1) year of Aftercare at time submitting One Year Sobriety Notebook. This is to include beginning and ending dates of attendance, dates of missed sessions and plans to make up any missed sessions. Frequency of aftercare meetings and length of time attended.
4. Statement addressing your participation and recovery activities.
5. If the counselor is related to you in any manner, a statement identifying the relationship is required.

## **ITEM 6: Relapse Prevention Plan**

Aftercare should involve discussing your personal Relapse Prevention Plan with your counselor. Submit a copy of the Relapse Prevention Plan you have written and include the date it was completed. If it was completed more than two (2) months ago, indicate on the Plan when it has been reviewed and updated by you.

Your Relapse Prevention Plan must include:

1. Documentation of any insights into the events that led you to the monitoring program.
2. How your drug/alcohol use/abuse affected patient care and coworkers.
3. A brief description of your support system.
4. Identification of your individual triggers and any situations which would be high risk for you).
5. A plan of action to minimize acting on any of these in relapse mode.
6. Any concerns about potential work settings and the impact of recovery.
7. Thoughts about desired areas of practice and potential employers/employment settings.
8. Describe the particular schedule you will be seeking (hours, days of the week, full or part-time).
9. Identify how you plan to maintain your recovery program once you return to practice.
10. Rate where you see yourself in recovery on a scale of 1-10, with 10 being optimal recovery. Explain the reason for and meaning of the rating you assign.

**ITEM 7: Addictionologist Evaluation and Evidence of Compliance**

You are required to have an evaluation by an addictionologist regarding your readiness to return to the practice of nursing. **If you current primary address is in North Carolina** you must see an addictionologist on our current participating addictionologists list. Contact the CDDP Monitoring Coordinator at (919) 782-3211, ext. 283 for a current list of Board participating addictionologists.

**If you live outside of North Carolina** you must have an evaluation by an addictionologist, a physician who is a member of the American Society of Addictions Medicine (ASAM), American Board of Addictions Medicine (ABAM) or the American Psychiatric Association (APA) and is certified in addictions medicine. You must submit a copy of the addictionologist's ASAM/ABAM/APA credentials and a copy of his/her curriculum vitae to the CDDP Monitoring Coordinator. You will be notified whether an evaluation would be accepted from the addictionologist. Do not schedule an appointment/see the addictionologist for an evaluation until you receive approval from the CDDP Monitoring Coordinator to do so.

To comply with this Item, follow these instructions:

1. Have the evaluation no more than 2 months prior to the date you plan to submit your packet of information for review.
2. **At least two (2) weeks prior to the appointment with the addictionologist, submit to CDDP Monitoring Coordinator, in writing, the name, telephone number and appointment date with the addictionologist in order that board staff may speak with him/her prior to your appointment. Failure to comply with this requirement could delay review of your petition for reinstatement.**
3. Sign a release with the addictionologist in order that he/she may discuss your case with Board staff.
4. Submit a signed copy of the addictionologist's evaluation. This includes the addictionologist signature and your signature.
5. Submit evidence of complying with all recommendations made by the addictionologist.

**Complete the following:**

Name of evaluating Addictionologist: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Date of evaluation: \_\_\_\_\_

Recommendations:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

For each recommendation on the previous page, explain how you have complied with the addictionologist's recommendations and submit supporting documentation:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**ITEM 8: Evidence of participation in a twelve-step program (AA or NA).**

***Attach attendance sheets for the last twelve (12) months, including the date you attended the meeting, the meeting name, and the signature of the Chair of each meeting. Evidence of attending three (3) meetings each week is required. You must use the enclosed AA/NA Attendance Sheet. Make additional copies of the sheet as needed.***

**Answer the following regarding your participation:**

1. When did you begin your twelve-step program? \_\_\_\_\_
2. Do you have a home group? Yes \_\_\_ No \_\_\_  
If yes, name of home group \_\_\_\_\_
3. First Name of sponsor \_\_\_\_\_
4. How long have you had this sponsor? \_\_\_\_\_
5. How often do you meet and/or have contact with your sponsor? (*A minimum of 3 times weekly is required with at least once being in person*)  
\_\_\_\_\_
6. How many sponsors have you had within the last three years? \_\_\_\_\_
7. Have you completed the twelve steps? Yes \_\_\_ No \_\_\_ if no, what step are you on? \_\_\_\_\_
8. Have you read the Big Book? Yes \_\_\_ No \_\_\_ (If you have not completed reading the Big Book, what chapter are you on?) \_\_\_\_\_
9. How has this program helped you with your recovery? (Be Specific).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. If you have not participated in a twelve-step program, have you participated in an alternative program such as Women in Sobriety or Rational Recovery or any other program? **[Note that participation in one of these programs in lieu of a twelve-step program must be approved in writing prior to your beginning your notebook by a North Carolina Board of Nursing participating treatment program and the NCBON]**  
Yes \_\_\_ No \_\_\_  
If yes, complete the following:  
Briefly describe the function of the program and how it has benefited you in recovery.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





**Have your sponsor NA/AA provide you with a letter in a sealed envelope addressed to CDDP Monitoring Coordinator including the following information:**

1. First name of sponsor
2. Length of time this person has been your sponsor
3. Identify the 12 step group, i.e., AA or NA
4. Describe your twelve-step activities and his/her general impression of your recovery status.
5. Describe frequency of contact with you including face to face and telephone.
6. Length of sobriety by this individual.
7. The step(s) on which you are working.
8. Letter may be signed first name only.
9. Provide telephone number in order for Board staff to speak with the sponsor.
10. Statement sponsor is not related to you in any manner.

**The required letter must be written by your sponsor. Do not provide the sponsor with a letter composed by you for his/her signature.**

**ITEM 9: Drug Screening Participation**

You must provide evidence of continuous successful **observed** screening with FirstLab for a period of one (1) year. The toll free number is 1-800-732-3784. FirstLab will provide you with a packet of information and you are required to call or check in online Monday through Friday, between 5:00 a.m. and 3:00 p.m., even on holidays, to determine if you are to screen. Directions will be included in the FirstLab packet regarding steps to follow if you are prescribed medications along with Board policies regarding random body fluid testing – follow these closely.

Successful screening is defined as:

1. Submitting prescriptions as required
2. Submitting specimens that are not dilute.
3. Calling or checking in online as required.
4. Screening as instructed.
5. Notifying FirstLab if planning to be out of town and thus obtaining a site to screen.
6. Possessing Chain of Custody forms as required in order to screen when so instructed.
7. Submitting screens which are clean and are not positive for alcohol, non-prescribed and/or illegal drugs.
8. Avoiding foods/drugs which result in positive screens.

My drug(s) of choice/abuse are:

- |          |          |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

**Remember you are required to have successful continuous screening with FirstLab for a period of one (1) year. Any failures to comply with the above criteria for successful screening would result in starting over with the required time frame of one (1) year.**

**Be advised that you must continue to call or check in online for drug screening and screen when selected after you submit your One Year Sobriety Notebook.**

### **ITEM 10: Criminal Record Information**

**You are required to provide information as to whether or not you have ever been convicted or pled guilty to a misdemeanor or felony and whether or not there are any charges pending whatsoever. DWIs are to be reported. Even if you are certain we have information regarding any prior convictions/charges, you are to include ALL of your criminal record.**

**If you have never been convicted of a crime/have no pending charges, sign this statement:**

*There have never been any convictions against me in the criminal courts and there are no charges pending whatsoever. This includes Driving Under the Influence and Driving While Impaired.*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**If, after you submit your packet, you should have charges against you:**

1. Call the Monitoring Coordinator at (919) 782-3211 ext. 283 and inform her.
2. Submit the information in writing addressed to CDDP Monitoring Coordinator.

**If you have a criminal record:**

1. Provide a list, written by you, of each charge/conviction and along with an explanation regarding each entry.
2. Submit a certified criminal record from each county in which you have ever been convicted. These documents should reflect every charge/conviction you have listed and explained.
3. For any convictions within the last five (5) years, submit certified documents indicating you have satisfied all conditions of the judgment(s).
4. If you have convictions for which you have not satisfied all conditions of judgment, submit documentation regarding continued requirements.

*Example: If you are on supervised probation, your probation officer should submit a letter addressed to CDDP Monitoring Coordinator with the following information:*

- Reason and date supervised probation was imposed.
- Date of anticipated termination of supervised probation.
- Statement regarding your compliance with conditions of probation.
- If restitution is due, a statement regarding your balance and compliance with payments required.
- Name, telephone number and address of Probation Officer.

### **ITEM 11: Criminal Background Check (CBC)**

Effective 8/1/10, anyone requesting reinstatement of the license is subject to the following:

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

The application for the CBC is online at: [www.ncbon.com](http://www.ncbon.com). Under Licensure/Listing, Criminal Background Checks, click on Live Scan Application.

Or you can type this address into the URL field online:

<http://www.ncbon.com/dcp/i/licensurelisting-criminal-background-checks-live-scan-application>

Note that it may take four (4) to eight (8) weeks for the CBC results to be returned to the Board office from the date submitted. Your notebook will not be complete until the results of the CBC are received in the Board office. It is therefore recommended that you submit the CBC no less than sixty (60) days prior to the date you plan to submit your One Year Sobriety Notebook to the Board.

### **ITEM 12: Refresher Course Information**

In accordance with the Nursing Practice Act, 90-171.35, if it has been at least five (5) years since you have held a nursing license you will be required to take a Board approved Refresher Course. **You may not begin any portion of the Refresher Course until after you have submitted your notebook and have signed section I of the Chemical Dependency Discipline Program (CDDP) contract. The Refresher Course will fulfill the entire Continuing Competence requirement upon reinstatement of the license (See Item 17, page 26).**

**ITEM 13: Health Care Providers: Medications, Providers, Diagnosis**

**Provide a list prepared by you of all medications you are taking to include prescribed medications, over the counter medications, herbs, reasons for taking all substances, dosage, and plans to continue.**

List your current health care providers. Specify one primary care provider who is aware of all medications you are taking. You must include all health care providers you have seen in the past year that have prescribed medications. *(Include address and telephone number with area code):*

1. Primary Care Physician - \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_
5. \_\_\_\_\_  
\_\_\_\_\_

**Have each provider listed above provide you with an original letter on his/her letterhead stationery addressed to CDDP Monitoring Coordinator stating:**

1. He/she is aware of your history of chemical dependency/abuse and your drug(s) of choice/abuse. He/she must list your drugs of abuse.
2. List of medications prescribed; reason for prescribing; dosage; plans to continue medications.
3. If prescribing narcotics, an in-depth explanation and the diagnosis.
4. Diagnosis for which he/she is treating you.
5. Telephone number of provider.
6. The primary care provider must identify himself/herself as such and list all medications you are taking to include those prescribed by other providers.
7. If you are receiving Suboxone or Methadone, an in-depth explanation must be submitted by your prescribing physician regarding the decision to use this method of treatment. A description of the Methadone/Suboxone Clinic with letters from your counselor and prescribing physician must be submitted.

8. If you are receiving Suboxone or Methadone, this must be addressed in your addictionologist evaluation.
9. If you are employed by and/or related to any of your health care providers, a statement identifying the relationship is required.

**Chronic pain and/or chronic disease issues:**

1. Documentation must be submitted by provider treating you for these conditions, which addresses the diagnosis and treatment plan.
2. If controlled substances are needed on a continuous basis, an evaluation from a pain management clinic is required. This must be completed no more than 60 days prior to your submission of materials for review. You must show compliance with recommendations made. Submit the evaluation, a letter from the evaluator documenting knowledge of your history of chemical dependency/abuse, plans for treatment and telephone number in order for Board staff to speak with this individual. These documents should be addressed to CDDP Monitoring Coordinator.

**Do you have a dentist?** Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, name and address:

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Have your dentist provide you with a letter on his/her letterhead stationery addressed to CDDP Monitoring Coordinator stating he/she is aware of your history of chemical dependency/abuse and your drug of choice/abuse. He/she must list your drugs of abuse. Dentist is to provide his/her telephone number. If the dentist is related to you in any manner, a statement identifying the relationship is required.

***All required letters must be written by the Health Care Provider. Do not provide the individual with a letter composed by you for his/her signature.***

### **ITEM 14: Pharmacy Information**

**Provide a list (on separate sheet of paper) of each pharmacy you have used for one (1) year prior to the submission of your information for review.**

**Contact each pharmacy used and request a printout of drugs received for one (1) year prior to the date you are submitting your material for review. The printouts should include:**

1. Name of the pharmacy
2. Telephone number of the pharmacy
3. Address of the pharmacy
4. Listing of all medications received showing date prescribed; provider; number of pills; number of refills

Sign a release with the pharmacist in order that Board staff may speak with him/her.

***You should carefully review each list to determine if EACH provider who has prescribed medication for you during the past year has submitted a letter regarding his/her awareness of your chemical dependency/abuse history.***

***If you are using more than one pharmacy, submit an explanation for this necessity.***

***If you are receiving samples of medications from your provider, submit a statement citing those medications received to include name and telephone number of the provider.***

**ITEM 15: Licensure Information in NC and other jurisdictions**

If you have never held a license outside of NC, please sign this statement:

**North Carolina is the only state in which I've ever had a license.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

I was **licensed by examination** in North Carolina in \_\_\_\_\_.

I **endorsed** to North Carolina from \_\_\_\_\_ (original state of license) in \_\_\_\_\_.

States in which I have ever been licensed or am currently licensed are listed below. (This includes all types of license: LPN and/or RN). *If discipline action is pending or has been taken in any states listed, contact the involved state and submit a certified copy of the related documents.*

1. State: \_\_\_\_\_ Year Licensed: \_\_\_\_\_  
Current status of license: Lapsed \_\_\_\_ Disciplined \_\_\_\_ Current \_\_\_\_
2. State: \_\_\_\_\_ Year Licensed: \_\_\_\_\_  
Current status of license: Lapsed \_\_\_\_ Disciplined \_\_\_\_ Current \_\_\_\_
3. State: \_\_\_\_\_ Year Licensed: \_\_\_\_\_  
Current status of license: Lapsed \_\_\_\_ Disciplined \_\_\_\_ Current \_\_\_\_

**Other Healthcare Related Licensure/Certification:**

Have you ever held any other type of healthcare related licensure(s) / certification(s) (i.e. paramedic, dental hygienist, etc.)? Yes \_\_\_\_ No \_\_\_\_

1. License/Certification: \_\_\_\_\_  
State: \_\_\_\_\_  
Year Licensed: \_\_\_\_\_  
Current status of license: Lapsed \_\_\_\_ Disciplined \_\_\_\_ Current \_\_\_\_
2. License/Certification: \_\_\_\_\_  
State: \_\_\_\_\_  
Year Licensed: \_\_\_\_\_  
Current status of license: Lapsed \_\_\_\_ Disciplined \_\_\_\_ Current \_\_\_\_

Have you ever had discipline action against a non-nursing licensure/certification?  
Yes \_\_\_\_ No \_\_\_\_

If yes, attach certified documents from the licensing/certifying agency.

### **ITEM 16: Releases from Providers**

You are required to sign releases with all providers in order that they may speak freely with Board staff regarding any and all diagnoses, treatments, medications, recommendations and outcomes.

List the individuals and agencies with which you have current signed releases:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Beginning with area code: \_\_\_\_\_

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Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Beginning with area code: \_\_\_\_\_

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Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Beginning with area code: \_\_\_\_\_

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Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Beginning with area code: \_\_\_\_\_

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Name: \_\_\_\_\_  
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Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: Beginning with area code: \_\_\_\_\_

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## **ITEM 17: Continuing Competence**

**You must meet all Continuing Competence requirements in addition to meeting all other requirements as indicated in this Notebook.**

For questions about Continuing Competence requirements, go to:

<http://www.ncbon.com/content.aspx?id=1078>.

If you have further questions you may contact the Continuing Competence Coordinator at (919) 782-3211, ext. 281.

### **ITEM 18: Reference Letters**

**You may submit no more than 3 character reference letters regarding your readiness to return to the practice of nursing.**

**Individuals who are aware of your recovering status and your nursing abilities should write these letters.**

Letters should be addressed to CDDP Monitoring Coordinator and an address and telephone number must be provided. If the writer is related to you in any manner, this should be indicated and explained. In accordance with G.S. 132.1 (b), information becomes public record upon receipt in the Board office.

***Do not compose the letters for the individuals to sign.***

## ATTACHMENTS

### **The North Carolina Board of Nursing** **Chemical Dependency Discipline Program (CDDP) Description**

The Chemical Dependency Discipline Program (CDDP) is a three (3) year monitoring program for licensees who are chemically dependent and have violated the Nursing Practice Act. Participation in the Program is public information and is published on the North Carolina Board of Nursing website.

Licensees may be offered participation in the CDDP through the following:

1. After unsuccessful participation in one of the Board's drug monitoring programs and submission of evidence of a minimum of one (1) year of sobriety.
2. Acceptance of a sanction offer in a Letter of Charges or Published Consent Order.
3. Administrative Hearing
4. Licensure Review Panel

Once a licensee decides to enter the CDDP, the following requirements must be met in a designated period of time:

1. Licensee must have an evaluation by a Board approved treatment program and must follow recommendations by the treatment program regarding treatment regime.
2. If Licensee is already involved in treatment, Licensee will sign a release of information allowing treatment information to be shared with the Board. In the event the current treatment regime is not consistent with the philosophy and requirements of the Board, Licensee will be referred to a Board approved treatment program for an evaluation and determination of treatment.
3. After Licensee has complied with the treatment requirements and the requisite documentation has been received, Licensee will be scheduled to come to the Board office for an intake interview conducted by the Drug Monitoring Coordinator.
4. If it is determined that Licensee has complied with the Board requirements, Licensee will sign a Program contract during the interview.

The Board may require a temporary suspension of the license. The purpose of the suspension is to improve the Licensee's prospects of successfully returning to practice by allowing time for Licensee to become grounded in recovery before returning to work.

Licensee will be required to submit the following reports for the duration of the Program:

- a) Self Reports
- b) AA/NA Verification Forms
- c) Counselor Reports
- d) Probation Reports (if applicable)
- e) Work Performance Evaluation Reports (after formal approval to return to work)

**Licensee will also be required to submit to random observed drug screens throughout the entire period of participation in the program. Licensee is responsible for all costs for drug screening and treatment.**

To petition for reinstatement, Licensee must be current with all required reports, compliant with drug screening requirements and submit a packet of information demonstrating recovery. Licensee may then be scheduled to appear before the Re-Entry and Reinstatement Committee to request reinstatement.

Once the Re-Entry and Reinstatement Committee determines that Licensee is ready to return to practice, Licensee will be reinstated with probationary conditions and restrictions. Practice restrictions include the following in addition to other restrictions to practice as deemed necessary by the Board to ensure the safety of the public:

- a) may not work 11 p.m. – 7 a.m. or be scheduled to work more than forty (40) hours per week for at least one (1) year.
- b) shall not work more than twelve (12) hours in a twenty-four (24) hour period for at least one (1) year.
- c) shall not have access to or be accountable for controlled substances for at least one (1) year.
- d) shall not work in critical care specialty areas or the ER for at least one (1) year.
- e) shall not work in a substance abuse treatment facility for at least one (1) year.
- f) shall not work for more than one (1) nursing employer at a time for at least one (1) year.
- g) Shall not float from unit to unit within a facility for at least one (1) year.
- h) shall work under the direction of an on-site RN for at least one (1) year.
- i) may not work as a CRNA, for a staffing agency, or in Home Health/Hospice for at least two (2) years.

Prior to returning to a licensed position, the Program must approve Licensee's potential employment during a scheduled Work Site Teleconference. The Drug Monitoring Coordinator, Licensee and potential employer engage in a conference call regarding program participation and monitoring requirements. Once the Drug Monitoring Coordinator approves a position, Licensee may return to licensed nursing practice. Licensee must work in a licensed nursing position for a minimum of three (3) years without any relapses to complete the Program.

If the Drug Monitoring Coordinator has evidence the Licensee is not in compliance with the Program, participation in the Program will be terminated. The participant may withdraw from the Program at any time. When Program participation is terminated (either for non-compliance or participant withdrawal), the license will be suspended for a period of time as outlined in the Program contract.

If you have any further questions about the Chemical Dependency Discipline Program (CDDP) contact the CDDP Monitoring Coordinator at (919) 782-3211.

## Procedures Related to Drug Screening

### ▪ Beginning Participation in Drug Screening

1. Contact FirstLab as indicated in Item #9 of this packet. FirstLab will mail you Chain of Custody Forms (COCs) and provide you with location(s) in your area where you may screen. If you have questions about other sites, please consult FirstLab.
2. FirstLab will provide you with a unique Participant Identification Number to write on your COCs each time you test and which you will use to access the system.
3. **You must begin calling the Inter-Active Daily Voice Reponse (IVR) number, or logging in via the FirstLab website, the first business day after you receive your Participant Identification Number.**
4. **You are required to check in between 5:00 a.m. and 3:00p.m. Monday through Friday, even on holidays, and screen when selected to do so.** Establish a routine that reminds you to call or check in online with FirstLab—without fail.
5. When you are selected to screen, the automated FirstLab system will advise you of an Option number that you should check off on your COC. Ensure that you are listening to message and checking the appropriate Option as failure to do so is non-compliance.
6. **All drug screens are collected under direct observation.** It is **your responsibility** to ensure your specimen is collected under direct observation. It is strongly advised that you call the collection sites on test selection days to confirm they have the appropriate staff to conduct a same gender observed collection. It is also recommended you review the COC upon completion of the specimen collection to ensure it is noted correctly as “Observed” on the COC.
7. **Observed Collection Requirements**
  - The observer must be of the same gender as the NCBON participant. (The observer may be a different individual than the person serving as the specimen collector.)
  - The observer must enter the restroom or facility where urination occurs.
  - The observer will instruct the participant to raise his or her shirt, blouse, or dress/skirt, as appropriate, above the waist, just above the navel; and lower clothing and underpants to mid-thigh; and to show the observer – by turning around- that the participant is not in possession of a prosthetic or other device(s) designed to carry urine substitutes.
  - After the observer has determined that the participant does not have such a device, the observer may permit the participant to

return clothing to its proper position and then conduct the observed collection.

- The observer must personally and directly watch the urine pass from the participant's body into the collection container.
- **Participants must adhere to all other procedures and guidelines for Chain of Custody etc. as outlined in the enrollment packet from FirstLab.**

#### **8. Suspension from Drug Screening for Nonpayment / Missed calls and tests / Vacation and Traveling out of Town**

If you are suspended from drug testing by FirstLab for nonpayment, you will be given three (3) business days from the date of being suspended to be reinstated in the drug screening process.

Each day that your account remains on suspended status will be viewed as a failure to check in.

If you fail to take the necessary action required by the drug testing service to be eligible to participate in drug screening within the allotted three (3) days, you will be required to re-start the required one (1) year of clean observed drug screens.

#### **Name, Address and Phone Number Change**

Any change in name, address or phone number is to be submitted to FirstLab in writing or online within five (5) days of the respective change.

#### **Missed Calls/Web Check-In**

Upon registering for drug screening with FirstLab you will be provided a toll free number and web site login instructions to access FirstLab's Test Notification System Monday through Friday between 5:00 a.m. and 3:00 p.m. Establish a routine that reminds you to call or login to FirstLab's Test Notification system—without fail—for your urine drug screen. A pattern of failing to call or check in online with FirstLab can result in increased testing and/or termination of the monitoring contract.

#### **Missed Tests**

If you do not test, either because of failing to call on a day a test is to be completed, or not testing after calling and being instructed to test, you will be considered to have missed a test. **You must place a written explanation of any failure to screen in your notebook.** A pattern of failing to screen when selected can result in you having to re-start the required one (1) year of clean screens.

#### **Vacation or Traveling Out of Town**

Notify the testing service **a minimum of fourteen (14) days in advance** of any travel plans. They will provide instructions regarding **testing in an alternate site.**

Continue to call or login to FirstLab's Test Notification system Monday through Friday for testing.

### **Dilute Urine**

Dilution of urine has been used as a tool to help hide the presence of drugs in urine specimens. Specimen results reported as dilute by the laboratory are a concern to the Board even if they are reported as negative as well. Specimens that are extremely dilute may be considered as being substituted specimens that are not consistent with normal human urine. Urine specimens confirmed by the lab and verified by Medical Review as substituted specimens will be considered as evidence of your refusal to submit to a fair and accurate testing process. Specimens that are not dilute enough to be considered substituted may still be considered not suitable specimens for testing.

An evaluation by a physician will be required for repeated dilute urines.

Adherence to the following guidelines will help in avoiding dilute urines:

- A. Call in as early as possible to find out if you have to test that day.
- B. Have your specimen collected as early in the morning as possible.
- C. Eat your usual food.
- D. Drink your usual amount of fluids the day of collection; do not increase your fluids.
- E. Do not use caffeine within 6-8 hours of the specimen collection.
- F. If you cannot urinate at the collection site, you will be given up to 3 hours and up to 40 ounces of fluid to help you produce a specimen. You will not be allowed to leave the collection site until you produce a specimen. Leaving the collection site before you produce a specimen may be considered a refusal to take the drug test.
- G. Taking a diuretic within a few hours before the collection may cause dilute urine. If medically acceptable, do not take either prescribed or over the counter diuretics until after you have your specimen collected. It is your responsibility to discuss with your prescribing physician whether or not taking your prescribed diuretics later in the day is medically acceptable. It is your responsibility to call FirstLab to resolve any issues of medication dosage and collection timing prior to taking your drug test.
- H. The FirstLab Medical Director will review specimens identified as dilute the same as is done for positive drug screens **and notify you if test is failed. You are to place an explanation in your notebook as to why the screen was dilute and how it will be corrected in the future.**

- **Additional guidelines associated with urine drug screening are:**

Poppy seeds – Eating poppy seeds may cause a positive result. It is your responsibility to assure no intake of poppy seeds to cause this result. The excuse of poppy seed intake as the cause for a positive result will NOT be accepted.

Marijuana – Walking through a room where people are using, or attending a concert where marijuana is used should not cause a positive result, therefore, this will NOT be accepted as a reason for a failed urine screen.

**Alcohol and Alcohol Containing Products – You are required to remain drug and alcohol free. This includes ingestion of alcohol from alcohol containing products. This may include but is not limited to Over-the-counter cough syrups, mouthwash and hand sanitizing gel. Always look for alcohol content in OTC medications and products.**

- **Waiver Split Specimen**

If the test may not be completed due to insufficient quantity of specimen for testing, you have the option of waiving the requirement for a split specimen. A waiver of split specimen form is attached to be completed and given to the Lab staff.

You should be aware that if you waive the split specimen and have a positive screen, reconfirmation of the test may not be possible.

**FIRSTLAB**  
**100 High Point Drive, Suite 102**  
**Chalfont, Pennsylvania 18914**  
**1-800-732-3784**

***WAIVER OF SPLIT SPECIMEN***

I \_\_\_\_\_, am waiving the requirement for a split specimen on this date  
\_\_\_\_\_. I understand that the test may not be completed due to insufficient  
quantity of specimen for testing. If testing is incomplete due to “quantity not sufficient” it  
will be counted as a missed test. I also understand that there may not be enough  
specimen for confirmation testing (if required).

\_\_\_\_\_  
(Date)

\_\_\_\_\_

## **Suggestions Regarding Medications in Recovery**

A person in recovery should be cautious taking any medication, prescribed or over-the-counter (OTC), due to the risk of cross-addiction. Although a recovering person may have a specific substance(s) of choice, any controlled, mood altering or potentially abusable substance including alcohol may threaten recovery. Therefore, the Board makes the following recommendations:

1. **You are the person responsible for your recovery.**
2. Treat any use of a controlled drug or OTC drug, if it is mood altering, as a potential trigger for relapse.
3. You are responsible for reading all labels to ensure products used are alcohol free and safe for use.
4. Accepting medication from others when you do not have your own prescription or OTC medication available poses a threat to your recovery. Do not borrow or accept any medication from others.
5. Certain prescription drugs are not controlled but have potential for abuse, including ULTRAM and FIORICET.
6. The Talbott Recovery Campus in Atlanta, Georgia, has a comprehensive Medication Guide available for download. You are encouraged to download a copy and review the guide. The guide is maintained by the Talbott Recovery Campus and periodically updated.

The Medication Guide is available at the website [www.talbottcampus.com](http://www.talbottcampus.com) and can be downloaded by going to the “Resource” tab and clicking on “Medication Guide” on the left side of the page.

7. Realize that some healthcare practitioners have not been educated about cross addiction and are unaware of the risk of cross-addiction for the recovering person.
8. Identify a single primary-care practitioner to provide for most or all of your health needs. Consider having your primary physician prescribe all medications, even those recommended by another physician.
9. Notify **all healthcare practitioners** (including but not limited to physicians, nurse practitioners, certified nurse midwives, physicians assistants, dentists, oral surgeons, podiatrists, etc.) that you are in recovery, and that great care should be used before prescribing a controlled, mood altering or potentially abusable medication
10. If you are unsure about the risk of a specific medication, consult with a healthcare professional such as a pharmacist, addictionologist, physician or nurse at your treatment facility or your counselor.

11. If you must take a prescribed or OTC controlled, mood altering or potentially abusable medication:
  - Discuss with your sponsor, treatment facility and peers in 12-step recovery.
  - Avoid dispensing the medication to yourself.
  - Have someone else pick up the medication from the pharmacy.
  - Advise your family, sponsor, treatment facility and peers in 12-step recovery when the medication is to be finished.
  - Attend additional 12-step meetings while you are taking the medication.
  - Discard unused medications.
  - Do not stockpile or “save in case needed.”
  
12. If you suffer from a chronic condition such as chronic pain or anxiety, discuss with your healthcare practitioner treatment of the condition(s) without addictive drugs, including non-medication treatments.
  
13. If others in your household are taking controlled, mood altering or potentially abusable medications:
  - Consider asking them to keep the medication in an area where you do not have access – examples: on the person, in a lock box or safe.
  - Discard unused medications.
  - Do not stockpile or “save in case needed.”

### **Documenting Over the Counter and Prescription Medications**

1. Over-the-Counter (OTC) antihistamines, decongestants and cough syrups must be reported in writing and submitted in your notebook.
2. **Prescription Identification Forms (attached) are to be submitted to FirstLab for all prescriptions written.** This includes samples, renewal of prescription and change in dosage of previous prescription. Medications received as part of a dental procedure, outpatient procedure or hospitalization are required to be documented.
3. **For the duration of the one (1) year of sobriety, completed Prescription Identification Forms are to be submitted to FirstLab within five (5) days of the date the prescription is written.** At the time a prescription(s) is written by your healthcare provider, have them IMMEDIATELY complete the form. AT THAT TIME ask the practitioner's staff to make a copy of the form and give the copy to you. YOU must submit the original form to FIRSTLAB, and YOU will place a copy of the completed form in your notebook. **Do not submit any forms to the Board directly while completing the notebook.**
4. It is suggested you provide your healthcare practitioner(s) with several copies of the Prescription Identification Form, and that you always have one with you for any visit to a health care practitioner.
5. Urine drug screens that are determined to be positive based on an existing prescription that was not reported upon beginning drug screening or during the period of drug screening will be considered a failed test. This will be considered noncompliance with the notebook.

## **Requirements For Reporting Prescription for Controlled or Monitored Substances**

- Submission of a completed **Prescription Identification form** to FirstLab and a copy placed in the notebook.
- **The above documentation must be received by FirstLab within five (5) days of the medication being prescribed.**

### **Additional Guidelines**

- It is strongly suggested that participants receive no more than a one-month supply of narcotic medication at a time in a single prescription, and that refills if needed, occur after an office visit. Phone refills are discouraged.
- If a participant is expected to receive a controlled or monitored substance for an extended time, or receives more than one such substance, an evaluation by an addictionologist to address potential impact on recovery may be requested.
- You must provide an updated Prescription Medication Provider Report must be completed by the prescribing physician for all PRN controlled or monitored substances every six (6) months regardless of whether you have medication remaining.



**PRESCRIPTION IDENTIFICATION FORM**

\_\_\_\_\_ is a participant in the NC Board of Nursing:  
 Licensee Name

<b>Alternative Program for Chemical Dependency</b>	<b>Chemical Dependency Discipline Program</b>	<b>Intervention Program</b>	<b>Probationary License</b>	<b>Requesting Reinstatement</b>
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**To the practitioner for the Drug Monitoring Program Participant:** Please take a few moments to complete the chart below.

1. This form must be completed by authorized prescriber only, to include signature, date, address and contact information.
2. By signing this form, you verify the information listed is correct and **that you have been informed that this individual is monitored through random drug screens.**
3. List all prescription medications.
4. Licensee is responsible for filing with NCBON and FirstLab, the drug screening company, within five (5) business days of the prescription date. Form can be faxed to numbers listed above.
5. Contact the Drug Monitoring Coordinator at 919-782-3211 with questions.

**I further acknowledge the participant has explained to me that his/her drug(s) of use and/or abuse have been:**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Date of Prescription	Name of Medication	Dosage & Frequency	# Prescribed	# Refills	Reason for Medication	Controlled, Mood Altering or Potentially Abusable*
						Yes/No
						Yes/No
						Yes/No
						Yes/No

*\*If any medications are controlled, mood altering or potentially abusable, indicate the length of time the medication is to be used:*

\_\_\_\_\_ Date Prescription should be disposed or completed

Provider Name \_\_\_\_\_ Facility Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

\_\_\_\_\_  
 Provider Signature Date