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Ohio Board of Nursing *www.nursing.ohio.gov*
17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

PARTICIPANT TREATMENT PLAN FORM
For Use of Alcohol, Drugs of Abuse or Controlled Substances

Please submit this form directly to the Ohio Board of Nursing's Alternative Program for Chemical Dependency/Substance Use Disorders by mail or by fax (#614-466-0710).

Individuals participating in the Alternative Program for Chemical Dependency/Substance Use Disorders (Program) are required to abstain from the use of alcohol, drugs of abuse, and controlled substances, excepting the Participant's **time limited use** of these in accordance with your treatment plan for the Participant. To ensure the Participant's compliance with the Program requirements, the following information is needed concerning any and all prescriptions for alcohol, drugs of abuse, and controlled substances that you prescribe for the Participant.

Participant Name: _____

The above named Participant has informed me of his/her chemical dependency history and recovery status prior to my provision of treatment and/or prescriptions? Yes _____ No _____

Medications/Substances administered/prescribed, and duration of use:

Medication/Dosage/Frequency	**# Prescribed**	**Start Date**	**Stop Date**

Diagnosis or basis for the administration or prescription:

_____

Expected length of Participant's recovery:

_____

If the Participant is confined to home, please list the dates of confinement:

_____

_____ _____
Qualified Prescriber Signature Printed Name

_____ _____
Date Telephone Number

Effective April 2015