

**VERIFICATION OF PRESCRIBED MEDICATION & OFFICE VISIT
FOR RNP PARTICIPANTS**

To the Health Care Provider of the Recovering Nurses Program Participant:

Please take a few moments to complete the form below. The form must document prescriptions, reason for visit, diagnosis and any samples dispensed. Please mail or fax the completed form to the Board office.

Fax: 601-957-6301
Mail: 713 Pear Orchard Road
Suite 300
Ridgeland, MS 39157

If you have questions, please contact:

Marianne Wynn: 601-957-6287 or mwynn@msbn.ms.gov

Vanessa Gray: (601) 957-6288 or vgray@msbn.ms.gov

Section A: To be completed by the RNP participant.

Date: _____

RNP Participant Name (Print): _____

Nursing License Number: _____

Section B: The following section should ONLY be completed by the health care provider of the RNP participant.

_____ *I acknowledge that my patient has informed me that she/he is participating in the Recovering Nurse Program and that use of opiates, controlled or mood altering prescriptions will prohibit the patient from working in the field of nursing while under the influence of prescribed medications.*

PRACTITIONER NAME (PRINTED):	
PRACTITIONER SIGNATURE:	
OFFICE ADDRESS:	
OFFICE TELEPHONE AND FAX:	
PATIENT NAME (PRINTED):	
DATE OF SERVICE:	

VERIFICATION OF PRESCRIBED MEDICATION FORM

Name of Patient: _____

Pertinent Notes: _____

Date of visit, prescription date:	Type of Medication	Dispense Quantity	Dosage	# of Refills	Diagnosis	Expected Length of Treatment

NAME AND TITLE OF PERSON MAILING/FAXING FORM:

DATE FORM

MAILED/FAXED: _____