Mississippi Nurse Voluntary Program (MnVP)

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Sponsored and Supported by the Mississippi Board of Nursing

To All Potential Participants:

We are excited to have the opportunity to sit down with you and discuss your potential enrollment in MnVP.

Prior to meeting with us, we would like to give you some basic information about the program and request the completion of some paperwork in order to decrease the amount of time spent on paperwork and increase the amount of time our staff can spend addressing questions/issues important to you during your meeting.

MnVP was designed to assist nurses throughout the state with substance use and/or mental health issues by providing support through an alternative to discipline program (MS Admin Code Part 2826) . MnVP does this through a Monitoring Agreement.

Monitoring Agreements include:

- Nursing practice restrictions including single state status
- Employment restrictions (including restrictions in environments that are unsupervised and/or hours worked)
- Agreement to participate in drug testing through Affinity (including $75 credit requirement upon signing up and payment for all testing costs)
- Participation in peer support groups (AA, NA, Celebrate Recovery, Recovery Support Group, etc.)
- Participation in clinical recommendations from an approved BON provider
- Limitations on medications (over the counter and prescribed)
- Completion of monthly/quarterly reports
- Return to work assessment
- Disclosure of participation in the program to employer

It is also important to note that all costs are covered by the participant in the program and that all information included in the Pre-Intake Packet will be sent to investigations and/or legal if a Monitoring Agreement is not entered into to determine if further action is needed.

We look forward to discussing any questions you have about MnVP throughout the process.

Thank you,

Sheron Russell, BSN, RN
MnVP Case Manager

Casey A. Loper, LMSW
MnVP Program Manager

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MnVP Pre-Intake Packet

Personal Information:

Full Name: _____ Preferred Name: _____
Previous Name(s): _____
DOB: _____ SS#: _____ Contact #: _____
Preferred Pronouns: _____ Gender at Birth: _____
Home Address: _____
Mailing Address (if different): _____
Preferred Email Address: _____
Emergency Contact (Name and Phone #): _____

License Information:

Licensure Level/Certification#:_____
Status of MS License: Active Lapsed Inactive Applicant Other
If other, please explain: _____
If ARPN, list all practice sites and collaborating physicians:_____
List any other states in which you hold a nursing license: _____

Employment Information:

Are you currently employed as a nurse? _____
If yes, please list: Employer/Practice Name: _____
Employer/Practice Address: _____
Employer/Practice Phone #: _____
Please list any other places currently employed (nursing or not):
_____
_____
Do you have any current or past disciplinary action against your nursing license in any state?
If yes, please explain:_____
_____
Are you currently or have you previously participated in an alternative to disciplinary program?
If yes, please list what state, the dates, and reason: _____
_____
Please list any employment terminations or disciplinary actions while using your nursing license:
_____
_____
_____

Health Care Provider Information:

Please include provider's name, agency name, city/state, and phone #
Primary Care Physician:
_____
_____
Mental Health Prescriber:
_____
_____
Therapist:
_____
_____

MnVP Pre-Intake Packet

Medical/Mental Health Information:

Current/chronic medical concerns:

_____

_____

_____

Current medications (list name and dosage):

_____

_____

_____

Any inpatient treatment history for mental health?: Yes No

If yes, please list where and dates of stay: _____

_____

Legal Information:

Do you have any legal charges pending? Yes No

If yes, please explain (including the charge, misdemeanor/felony, jurisdiction, status, and next court date): _____

_____

_____

_____

Are you currently on any form of probation or parole? Yes No

If yes, please explain: _____

_____

Please list any malpractice claims, including outcomes: _____

_____

Substance Use History:

Substances used/abused (current):

_____

_____

Route(s) of Administration: _____

Substance Abuse Treatment History (any residential or outpatient, include dates):_____

_____

_____

Any history of use/abuse of other substances not currently being used: _____

_____

Do you consider yourself to have a substance use/abuse problem? Yes No

Have you ever diverted medication? Yes No

Have you ever diverted medication and replaced it with another medication? Yes No

If yes, please explain: _____

_____

_____

_____

MnVP Pre-Intake Packet

Please explain the circumstances that led you to want to be considered for MnVP:

Signature: _____ Date: _____

(Please note that your signature is a verification that all information is accurate and not an agreement to enroll in the program. If you do not enter MnVP for any reason, the pre-intake packet will be provided to the investigations and/or legal department(s) to determine next steps.)

INTERNAL USE ONLY

Person Receiving Packet:_____

Date Received by MnVP: _____