MISSISSIPPI BOARD OF NURSING
RESTORATION PROCEDURE

TO: Restoration Applicant
FROM: Legal Division

You have been sent this document in reply to your inquiry concerning the process to file an application for restoration of your nursing license.

An application for restoration may be accepted in the Board office no sooner than one year from the date of service of the Board's Order revoking the license/privilege, accepting surrender of the license/privilege, denying an application for restoration or reinstatement of the license/privilege, suspending the license/privilege, or denying an appli c ation for license/privilege.

The loss of one's license/privilege to practice nursing is a very serious matter. The Board of Nursing will restore a license/privilege only if the applicant submits a complete application and supporting documentation that represents compelling evidence that his or her license/privilege should be restored given the underlying misconduct that resulted in the loss of licensure/privilege. While the Board of Nursing has the authority to restore a nursing license/privilege, such restoration is not a RIGHT, and the burden of proof is on the applicant.

The Board of Nursing may consider a variety of issues relevant to the applicant's fitness .to practice safely; these include, when applicable, whether the factors that led to revocation, Surrender , suspension, or denial of the license/privilege are likely to recur, the remorse demonstrated by the applicant, whether the individual is currently competent to practice the profession safely and in accordance with the requirements governing such practice, and whether re-licensure/privilege would present any undue risk to the public.

The former licensee must carry the burden of proving that he or she is worthy of having the privilege of a nursing license/privilege restored. The Board will evaluate the applicant's complete application and supporting documentation in consideration of the applicant's burden and render a decision.

An example of supporting documentation/evidence that the Board evaluates includes, but is not limited to, the following:

1) Evidence of successful completion of continuing education.

2) Evidence of efforts made regarding rehabilitation specific to the conduct that resulted in the loss of the applicant's license/ privilege.

3) Supporting affidavits.

DIRECTIONS:

1. APPLICATION:
Please complete, sign and notarize your Application for Restoration of a Nursing License/Privilege. (Pages 1-6)

2. SUPPORTING AFFIDAVITS: You must submit Five (5) affidavits from individuals who have knowledge of the reason for the loss/denial of your license/privilege. These individuals should be able to verify your ability to practice nursing, your character, your behavior and your conduct after your license/privilege was revoked, surrendered, suspended, or denied. PLEASE NOTE: Three (3) of the five (5) affidavits must be from nurses with a license or privilege and in good standing. All supporting affidavits must be notarized.(Pages 7-8)

3. AUTHORIZATION TO RELEASE RECORDS: If you answered "yes" to question nine (9) on page two (2) of the application you will need to submit a signed authorization to release treatment records. Please submit one (1) copy with your application to the Board of Nursing and send your hospital(s)/treatment center(s) a copy. IT IS YOUR RESPONSIBILITY TO SUPPLY THE BOARD OF NURSING ATTN: LEGAL DIVISION WITH YOUR TREATMENT RECORDS ALONG WITH A STATEMENT FROM THE TREATING PRACTITIONER/ FACILITY REGARDING YOUR CURRENT PROGNOSIS AND DIAGNOSIS.

4. VERIFICATION OF LICENSURE IN ANOTHER STATE/ JURISDICTION: If you currently have or have ever had a nursing license and/ or privilege in another state or country, You must complete the Verification of Licensure for each state or country where you are or have ever been licensed/privileged. Follow the specific instructions on the form to make sure each verification is properly completed and mailed directly from the licensing authority to the Mississippi Board of Nursing, OR if that licensing board uses the NURSYS Verification System, then you must go on line and request that verification for MISSISSIPPI.

5. CONTINUING EDUCATION/ EDUCATION REQUIREMENTS: If you have not practiced as a nurse within the last five (5) years, you must submit evidence of continuing basic nursing competencies. See Chapter I, Rule 4.8 of the Board's Rules and Regulations referencing the required documentation to submit of continuing basic nursing competencies. You are responsible for maintaining said documentation prior to submitting said documentation with your application.

6. PROOF OF COMPLETION OF CRIMINAL PROBATION ; If you have been on criminal probation within the last five (5) years, you must provide proof of your completion of probation including payment of all fines.

7. DRUG RELATED OFFENSES: If your license was revoked, surrendered, suspended, or denied because of drug related offenses, you MUST document sobriety for the twelve months preceding submission of your application. Please see your Final Order for any conditions/stipulations to which you where required to comply. The Board's drug related recommendation is page 12 of the application.

   a) ALCOHOLICS ANONYMOUS/NARCOTICS ANONYMOUS CALENDARS: If your license was revoked, surrendered, suspended, or denied because of drug *I* alcohol related offenses, you MUST submit *AAI* NA Calendars for the twelve months preceding submission of your application. You are responsible for maintaining said AA/NA Calendars prior to submitting said calendars with your application. (Page 13)

   b) AFTER CARE REPORTS: If your license was revoked, surrendered, suspended, or denied because of drug *I* alcohol related offenses and you sought treatment, and were advised to begin aftercare, please submit A MINIMIMUM OF TWELVE MONTHS of aftercare reports.

   c) AFFINITY HEALTH DRUG SCREENING: Drug screens must be conducted in compliance with Board approved criteria; and by the Board's designated drug screening company. Any screens conducted or processed by any other agency will not be considered as Board approved. You will need to provide twelve (12) months of normal negative drug screens.

INSTRUCTIONS FOR SUBMISSION OF PACKETS:

You will need to submit one copy of your restoration packet for review by the legal staff prior to being set for hearing. The legal staff will review the packet and may request further documentation to be added to the packet. Once the staff is satisfied that your packet meets the requirements, it will be given to an attorney for final review. The staff may add documents or request further information from you.

Once your application packet has been approved by all staff as being complete, you will need to submit an original and (9) nine copies of all materials. Please include a copy of the Final Order which resulted in the loss of your license. (If you no longer have a copy of your Final Order, please see our website to obtain a copy.) **Each set of copies must be organized**

together to create a complete restoration packet, each packet of materials must be individually bound and include the following tabbed sections : Application and Supporting Affidavits; Treatment Records (if applicable), Verification of Licensure/ Privilege in Another Jurisdiction (if applicable), Continuing Education/ Documentation of Volunteer Work (if applicable), Documentation of Sobriety including twelve (12) months of normal negative tests (if applicable), etc. You may also submit letter(s) of recommendation from current employers. The final section should be the final order from the board and any other legal documentation.

The application must be typed or printed in black ink, for legibility purposes. Each set of final bound copies must be delivered to Board offices and addressed to : **Restoration.**

Upon receipt of your approved application, we will set your hearing date and notify you in writing of the date and time of your restoration hearing.

Please remember that the application will be accepted in the Board's Legal Department no sooner than one year from the date of service of the Board's order which removed or denied the license/privilege. Applications received prior to that date will be returned.

Should the Board in a formal hearing deny your request for restoration of your nursing license/privilege, you will have thirty (30) days from the date you receive the Board's Final Order to appeal that decision to the full membership of the Board. Should you waive your right to appeal, you must wait a year from the date you receive the Board's Final Order denying licensure to submit a new application for restoration.

Please note that the restoration process is subject to ongoing review and improvements in the current process may occur. You may download a copy of The Mississippi Nurse Practice Law, Rules and Regulations from our website at www.msbn.state.ms.us.

RECOMMENDATIONS FOR SUBSTANCE ABUSE/DEPENDENCE RELATED RESTORATION APPLICANTS

(1) That you be evaluated for chemical dependence by an assessor /agency approved by the Board and meeting the Board's criteria. You will need to follow all recommendations made by the assessor up to and including inpatient treatment, Intensive Outpatient Treatment, twelve months of aftercare and or Counseling. You will need to keep copies of all documents regarding recommendations, proof of treatment, and certificates/letters of completion of all recommendations to submit with your packet.

(2) That you obtain and keep the following documentation until you submit your restoration packet:

(a) Verification of attendance of AA/NA meetings, or some other Board approved twelve-step meeting, a minimum of three (3) per week for the 12 (twelve) months prior to submission of packet for restoration. The meetings will need to be documented on the board approved calendar form and list the date, time, location and name of meeting as well as the name and phone number of the group member verifying your attendance.

(b) Copies of random normal negative urine and blood screens, a minimum of one (1) a month. All screens should be performed by a person and an agency approved by the Board. Urine/blood/ or hairstrand screens must examine for drugs of abuse, including alcohol.

(c) Use of mood altering or opiate medications must be documented and will need to have the statements of the medical personnel justifying the use of these controlled substances.

(d) Any and all information regarding your failure to attend treatment recommendations as outlined above.

(e) Anyand all. information regarding your refusal to furnish a urine/blood/hair strand specimenon demand for the purpose of having a drug screen performed.

(f) Any information regarding the consumption or use of alcohol or any mood-altering substances, prescription and nonprescription.

PLEASE BE ADVISED THAT AFTER ONE FULL YEAR FROM THE DATE OF YOUR ; VOLUNTARY SURRENDER, REVOCATION OF LICENSURE OR ADMINISTRATIVE DENIAL THAT YOU WILL BE ELIGIBLE TO SUBMIT A FULL APPLICATION FOR RESTORATION OF YOUR LICENSE/PRIVILEDGE TO PRACTICE IN THE STATE OF MISSISSIPPI. AT THE TIME OF YOUR RESTORATION HEARING, THE BOARD HAS THE DISCRETION TO DENY YOUR RESTORATION REQUEST, ISSUE A RESTRICTED LICENSE, OR GRANT FULL LICENSURE RESTORATION.

FORM 1R
RESTORATION
(Revised 7/2011)

MISSISSIPPI BOARD OF NURSING

713 Pear Orchard Rd Suite 300
Ridgeland, Ms. 39157
TELEPHONE (601) 957-6300

OFFICE USE ONLY
Application Complete

APPLICATION FOR RESTORATION OF A NURSING LICENSE

(PRINT OR TYPE ALL INFORMATION)

PART A: GENERAL INFORMATION

NAME: _____ SOCIAL SECURITY NUMBER: ___-__-____
Last First Middle

DATE OF BIRTH: ____/____/____
Mo. Day Yr.

STATE ANY OTHER NAMES OR ALIASES YOU HAVE BEEN KNOWN BY: _____

LEGAL MAILING ADDRESS: _____ TELEPHONE (___) ___-____
Box or Street Work

_____ TELEPHONE (___) ___-____
City State Zip Code Home

PROFESSION: Registered Nurse _____ Mississippi RN License No: R _____ DATE ISSUED: ____/____/____
Mo. Day Yr.

Licensed Practical Nurse _____ Mississippi LPN License No: P _____ DATE ISSUED: ____/____/____
Mo. Day Yr.

Are you represented by an attorney in this matter? ☐ YES ☐ NO If yes, state name, address and telephone number below:

_____ (___) ___-____
Attorney Name Address City State Zip Code Telephone

My primary state of residence is ( ) Mississippi ( ) other state (specify) _____

PART B: GENERAL QUESTIONS

Other than the actions associated with the revocation/surrender/suspension/denial of your license,

1. Have you ever been convicted of a crime (felony or misdemeanor) in any state or country? ☐ YES ☐ NO
2. Are there any pending criminal charges against you? ☐ YES ☐ NO
3. Have you been found guilty of professional misconduct, unprofessional conduct, incompetence, or negligence in any state or country other than Mississippi? ☐ YES ☐ NO
4. Has any licensing authority suspended, revoked or restricted your license or imposed any other disciplinary action? ☐ YES ☐ NO
5. Have you ever had charges brought against you for professional misconduct, unprofessional conduct, incompetence or negligence in any state or country other than Mississippi? ☐ YES ☐ NO
6. Have you ever been requested to appear before or submit an explanation to any licensing authority in regard to any charges or complaints? ☐ YES ☐ NO
7. Have you ever been denied a license or the opportunity to take an examination for licensure by any licensing authority? ☐ YES ☐ NO
8. Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures? ☐ YES ☐ NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PROVIDE A FULL EXPLANATION ON A SEPARATE SHEET OF PAPER FOR EACH ITEM. YOU MUST INCLUDE ANY VERIFYING DOCUMENTATION FOR EACH ITEM.

9. Have you ever received counseling or treatment connected with the revocation/surrender/suspension/denial of your license? ☐ YES ☐ NO
If yes, (1) attach a statement from the treating practitioner/facility regarding your current diagnosis and prognosis, including your ability to resume the practice of nursing, and (2) present an executed release to each practitioner or facility where you have had treatment to have treatment records submitted directly to the Board. Treatment records must include the Intake, Admission Diagnosis, Plan of Treatment, Discharge Summary, Discharge Diagnosis and Recommendations. A release form has been enclosed for your convenience.

10. List the following requested information for each counseling or treatment received which is related to the reason for the revocation/surrender/suspension/denial of your license.

FROM MONTH-YEAR	TO MONTH-YEAR	TYPE OF TREATMENT	PLACE & ADDRESS OF TREATMENT

PART C. CONTINUING EDUCATION

1. List any continuing education credits you earned since the revocation/surrender/suspension/denial of your license. Submit proof for each item listed. If additional space is required, attach a separate list.

COURSE/SEMINAR ATTENDED	DATE(S) OF ATTENDANCE	CREDIT HOURS	CHECK ONE OPTION
			☐ CORRESPONDENCE ☐ ATTENDED CLASS
			☐ CORRESPONDENCE ☐ ATTENDED CLASS

2. List other methods, if any, that you have used to maintain/improve your knowledge and skill in the practice of your profession since the date of revocation/surrender/suspension/denial of your license. If additional space is required, attach a separate list.

3. Explain how the educational preparation (listed in items 1 & 2 above) is relevant to the specific conduct that resulted in the loss of your license.

PART D. COMMUNITY SERVICE

List any community or public service related activities you have been involved in since the date of the revocation/surrender/suspension/denial of your license. Submit documentation for each activity listed. If additional space is required, attach a separate sheet.

TYPE OF ACTIVITY	NAME OF ORGANIZATION	DATE(S)	NUMBER OF HOURS

PART E - LICENSURE STATUS

1. Are you licensed or have you ever held a nursing or health related license in any other state or country? ☐ YES ☐ NO

If yes, list each jurisdiction. A Verification of Licensure in Another Jurisdiction (Form 3R) must be submitted for each license (including all inactive Licenses) listed.

State or Country	Profession	Date License Issued	Any Limitations on License	If License is not Current, Explain Below or on Separate Sheet

2. Have you ever held or do you currently hold a Mississippi license in another profession? ☐ YES ☐ NO

If yes, complete section below.

Profession	License Number	Date of Licensure	Current Status

PART F - EMPLOYMENT HISTORY

List all employment chronologically since graduation from your nursing school to the present. Explain periods of unemployment. If additional space is required, attach a separate sheet. Begin with date of graduation from your nursing school and end with the present date.

FROM Month – Year	TO Month - Year	REASON FOR EMPLOYMENT TERMINATION / RESIGNATION	Employers
			Employer: Address: Position held: Telephone (___) ___-____ Duties:
			Employer: Address: Position held: Telephone (___) ___-____ Duties:
			Employer: Address: Position held: Telephone (___) ___-____ Duties:
			Employer: Address: Position held: Telephone (___) ___-____ Duties:
			Employer: Address: Position held: Telephone (___) ___-____ Duties:

PART G - PROFESSIONAREHABILITATION ACTIVITIES

List any professional practice-related rehabilitation activities which you have undertaken to address the action(s) which resulted in the loss or denial of your license. Submit documentation for each activity listed. If additional space is required, attach a separate sheet.

PART H - SUBMISSION OF AFFIDAVITS

An application for restoration will not be considered complete without at least 5 notarized supporting affidavits (Form 4R) attached. Three of the required five affidavits must be from individuals licensed and in good standing in your profession. List the names and telephone numbers of the individuals for which you have attached affidavits. If additional space is required, attach a separate sheet. Include the required affidavits along with this application for restoration form and return to the address shown below.

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name _____ Telephone Number _____

PART 1- CERTI'FICATION

Under penalties of perjury, I declare and affirm that the statements made in this application, including accompanying documents are true, complete, and correct. I understand that any false or misleading information in, or in connection with my application may be cause for denial or loss of licensure.

_____ _____

Signature of Petitioner Date

Sworn to before me this ____day of ----------

_____

Signature of Notary

ATTACH ARECENT INDIVIDUAL PASSPORT TYPE PHOTOGRAPH

RETURN TO: Mississippi Board ofNursing

FORM 2R
RESTORATION

MISSISSIPPI BOARD OF NURSING
713 South Pear Orchard Rd Suite 300
Ridgeland, Ms. 39157
TELEPHONE (601) 957-6300

This form is to be completed ONLY by applicants who answered "YES" to question # 9 in Part B of Form 1R.

AUTHORIZATION TO RELEASE TREATMENT RECORDS

INSTRUCTIONS: If you answered "Yes" to question # 9 in Part B of the Application Form 1R, you must complete a separate authorization form for each professional practitioner and/or hospital/facility where you have been treated. If additional forms are needed, this form may be photocopied. DO NOT MAIL THIS AUTHORIZATION SEPARATELY. Completed authorizations must be attached to your application for restoration.

I, (print your name here) _____, request and authorize the **below-named** licensed professional or practitioner or the **below-named** hospital or facility, to disclose fully to the Mississippi Board of Nursing and its authorized representatives all information and records relating to the diagnosis, treatment, prognosis made for and/or on my behalf, or service rendered for and/or on my behalf, by the said licensed professional, practitioner, hospital, or facility. I understand that this consent may be withdrawn by me at any time except to the extent that the action has been taken in reliance upon it. In any event, this consent shall expire when the Mississippi Board of Nursing has taken final action on my petition for restoration of my license. I also understand that my disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

Name of practitioner _____ License No. _____

or

Name of hospital or other facility _____

Signature of petitioner _____ Date _____

FORM 3R
RESTORATION

MISSISSIPPI BOARD OF NURSING

713 South Pear Orchard Rd Suite 300
Ridgeland, Ms. 39157
TELEPHONE (601) 957-6300

This form is to be completed ONLY by applicants who are or have been licensed in another jurisdiction.

VERIFICATION OF LICENSURE IN ANOTHER JURISDICTION

APPLICANT INSTRUCTIONS

1. Complete Sections I and II. Enter your name as it appears on your Application Form 1R.
2. DO NOT RETURN THIS FORM WITH YOUR APPLICATION. Send this form to each state or country where you are or have ever been licensed and request that they complete Section III on back. Be sure to include any fee(s) required. If additional forms are needed, this form may be photocopied. You must provide Verification of Licensure and the status of your license from ALL jurisdictions where you are or have ever been licensed. Verifications must be in English or otherwise submitted with an official translation.

SECTION I: APPLICANT INFORMATION

1. SOCIAL SECURITY NUMBER ___ - __ - ____ 2. BIRTH DATE ___ - __ - ____ (MO. DAY YR.)

3. FULL NAME
   LAST _____
   FIRST _____
   MIDDLE _____

4. ADDRESS
   STREET _____
   CITY _____
   STATE ____ ZIP CODE _____

5. NAME OF JURISDICTION _____ DATE OF LICENSURE _____ (MO. DAY YR.)

NAME UNDER WHICH YOU ARE OR WERE LICENSED IN THAT JURISIDICTION

LICENSE NUMBER _____ PROFESSION _____

SECTION II: APPLICANT RELEASE

I request and authorize the above named jurisdiction to release any and all information pertaining to my license, including but not limited to, disciplinary actions and pending charges.

SIGNATURE OF APPLICANT _____ DATE _____

JURISDICTION'S CERTIFICATION IS TO BE COMPLETED ON REVERSE SIDE

SECTION III: OTHER JURISDICTION'S CERTIFICATION

To be completed by the licensing authority. Do not return to applicant. Return completed form directly to: Mississippi Board of Nursing, 1935 Lakeland Drive, Jackson, MS 39216-5014.

1. a. Has the applicant named in Section I been subject to any disciplinary action? ☐ YES ☐ NO

   b. Are any charges pending against this individual? ☐ YES ☐ NO

   If the answer to either of these questions is "yes", please attach certified copies all relevant information.

2. LICENSE NUMBER _____ DATE ISSUED ___ / ___ / _____
   MO. DAY YR.

   Expiration of most recent registration ___ /___/ _____ Is the license current? ☐ YES ☐ NO
   MO. DAY YR.

I certify that the information shown above is true and correct, according to the records of this office.

Name of Jurisdiction: _____

Name: _____

Title: _____ (BOARD SEAL)

Signature: _____

Date: _____

Telephone Number: (_ _ _) _ _ _ - _ _ _ _

FAX Number: (_ _ _) _ _ _ - _ _ _ _

SECTION IV: OPTIONAL COMMENTS

To be completed by the licensing authority.

Comments _____

_____

_____

_____

_____

_____

_____

_____

Return completed form directly to:

Mississippi Board of Nursing, 713 South Pear Orchard Rd, Suite 300 Ridgeland, MS 39157
Telephone: (601) 957-6300

FORM 4R
RESTORATION

MISSISSIPPI BOARD OF NURSING

713 South Pear Orchard Rd Suite 300
Ridgeland, Ms. 39157
TELEPHONE (601) 957-6300

SUPPORTING AFFIDAVIT

INSTRUCTIONS

APPLICANT: Complete items A and B and provide a copy to each of your affiants/references. Attach completed original of each affidavit to your restoration application.

AFFIANT/REFERENCE: Complete items 1 - 5, sign the affidavit in the presence of a notary public, and return the form to the applicant.

In the Matter of the Application of

A. _____
(Applicant's Name)

for the restoration of (his/her) license to practice as a

B. _____
(Type of License)

in the State of Mississippi.

This affidavit is in support of an application for restoration of a nursing license.

State of _____)
) ss:
County of _____)

_____, being duly sworn deposes and says:

1. My name is _____.
(affiant/reference name)

I reside at _____.
(affiant/reference address)

My daytime telephone number (include area code) is _____.

My occupation is _____.

I am a licensed professional ☐ YES ☐ NO

If yes, Profession:_____State:_____

License Number:_____ Is the license current? ☐ YES ☐ NO

Date License Issued: ____/____/____ Expiration Date of Last Registration:____/____/____

I am of sound mind, capable of making this affidavit and personally acquainted with the facts stated herein.

I make this affidavit in support of_____ application for restoration

of (his/her) license to practice as a _____in the State of Mississippi.

2. I have known the applicant for _____ years and _____ months through the following contacts:

_____

_____

_____

3. It is my understanding that the applicant's license was revoked, surrendered, suspended or denied because (provide a detailed statement of circumstances which led to revocation/surrender/suspension/denial of license):

_____

_____

_____

_____

4. It is my understanding that the applicant has undertaken the following activities to rehabilitate (himself/herself) (provide a detailed statement of activities):

_____

_____

_____

_____

5 I recommend that the applicant's license be restored because:

_____

_____

_____

_____

_____

(Signature of Affiant/Reference)

Sworn to before me this _____day of _____, _____.

Notary Public_____

RESTORATION APPLICATION CHECK LIST
DRUG RELATED

Name of Applicant/ Respondent _____
Sent to Board – Restoration Staff_____

_____ Application (notarized) by Respondent

_____Current Passport Style Photograph of yourself.

_____ 5 notorized affidavits, 3 nurses 2 lay people

_____ Signed Authorization to Release Treatment Records* and copies of those records

_____ Verification of Licensure in other jurisdiction*

_____ Normal negative Drug Screens of Respondent for a minimum of twelve (12) months*

_____ AA/NA Calendars of Respondent for a minimum of twelve (12) months*

_____ If Applicable Aftercare Reports of Respondent for a minimum of twelve (12) months*

_____ Proof of Completion of Education Courses*

_____ Assessment Conducted/ Submitted by Board Approved Assessor*

_____If under criminal probation, non-adjudication, drug court etc.
Must provide copies of all legal agreements and proof of completions of all terms including payment of all fines etc.

_____ If any of the above items *were not received to substantiate a complete Restoration Application*, please provide all missing requisite documentation to the Board of Nursing so that your application can be considered for restoration.

The Board of Nursing will restore a license **only if** the applicant can present compelling evidence to the Board of Nursing that his or her license should be restored in the face of misconduct that resulted in the loss of licensure. While the Board of Nursing has the authority to restore a nursing license, such restoration is not a RIGHT, and the burden of proof is on the applicant.

Upon receipt of the missing information as indicated above, your application will be eligible to be considered as a complete restoration application. Should you wish to fax this information to the Board, the number is (601) 957-6301 attn: Marianne Wynn

MISSISSIPPI BOARD OF NURSING

RESTORATION APPLICANT 12 STEP MEETING CALENDER

NAME_____ **REPORT FOR THE MONTH** _____20_

This form may be used to document your weekly attendance at AA/NA meetings. You will need to provide the following information for each meeting attended (see example in first block):

D: Date of Attendance
G: Name of Group & City Where Located
T: Time of meeting
V: Signature or first name and last initial of person verifying your attendance
P: Phone number of person verifying your attendance

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
D: G: T: V: P:						

MSBN 713 Pear Orchard Road, Suite 300 Ridgeland, MS 39157 mwynn@msbn.state.ms.us

MISSISSIPPI BOARD OF NURSING
713 Pear Orchard Road
Suite 300
Ridgeland, MS 39157
Fax: 601-957-6301

RESTORATION APPLICANT
EMPLOYER MONTHLY EVALUATION

For The Month Of:_____

Facility Name: _____ **Day shift** _____ **Night Shift**_____

Address: _____

Supervisor: _____ **Title:** _____

Supervisor Phone: _____ **Employee Unit Phone:** _____

Employee Name: _____ **Nurse License No:**_____

Number of Hours Scheduled to Work:_____ **Number of Hours Worked:**_____

1. **APPEARANCE**
   a. Neat, appropriately dressed [ ]
   b. Fair [ ]
   c. Poor [ ]
   d. Unacceptable [ ]

2. **ATTENDANCE**
   a. Number of absences _____
   b. Date(s) of absences_____
   _____
   c. Reason for absence _____
   _____

3. **PUNCTUALITY**
   a. Arrives on time
   b. Number of times tardy _____
   Reason for tardiness_____
   _____

4. **RELIABILITY**
   a. Very Dependable [ ]
   b. Average [ ]
   c. Poor [ ] explain _____
   _____

5. **COMMUNICATION SKILLS**
   a. Excellent [ ]
   b. Average [ ]
   c. Poor [ ]

6. **TEAMWORK PRACTICE**
   a. Excellent [ ]
   b. Average [ ]
   c. Poor [ ]

7. **DOES EMPLOYEE SEEK SUPERVISION WHEN NEEDED?**
   a. Yes [ ]
   b. Not Consistently [ ]
   c. No [ ]

8. **CLINICAL PERFORMANCE**
   a. Above Average [ ]
   b. Average [ ]
   c. Fair [ ]
   d. Unacceptable [ ] (Explain)

_____

COMMENTS ON PERFORMANCE: _____

_____

_____ _____
EMPLOYEE'S SIGNATURE **DATE**

_____ _____
SUPERVISOR'S SIGNATURE **DATE** 1/2015

AFFINITY ONLINE SOLUTION PARTICIPANT INTAKE INFORMATION

TODAY'S DATE:_____

NAME:_____

SSN:_____

DOB:_____

MARITAL STATUS:_____

ADDRESS:_____

ZIP:_____

CITY:_____

STATE:_____

COUNTY:_____

EMAIL ADDRESS:_____

HOME PHONE:_____

MOBILE PHONE:_____

EMPLOYER:_____

ADDRESS:_____

EMERGENCY CONTACT:_____

ADDRESS:_____

PHONE:_____

In order to receive your pin # from AOS, you must send this completed form to the attn. of Marianne Wynn at the MSBN mwynn@msbn.ms.gov, 601-957-6301, you may scan and email it, fax it or mail it.

PIN# FROM AOS:_____

PARTICIPANT SIGNATURE

Affinity eHealth.com

PERSONAL AND CONFIDENTIAL

Dear

The Mississippi Board of Nursing has selected Affinity eHealth as your alcohol and/or drug testing service provider. This packet contains material describing the program features and activation instructions for your Affinity eHealth account.

How to Activate Your Account with Affinity eHealth

You must activate your Personal Compliance account online at http://www.affinityehealth.com/cms/msbn **and complete the activation process within 48 hours following receipt of this package or you may be considered non-compliant.** Review the enclosed *Affinity Activation Guide* for more information and step-by-step instructions. Once logged in, click on Manage Profile under the **Participant** tab and **Contact** tab to confirm that your demographic information is correct.

For the purpose of activating your account, the month and year of your birth has been set to the value shown on the back of this letter. If this is not correct, please update it to the correct value on your personal **Profile** page after logging in online. Once it is updated, please use it whenever you call into the phone system. During activation, you will be required to make an **initial deposit** of **$65.00** into your account which will be used towards your first test. A unique **10-digit PIN number** has been provided to you and is shown on the back of this letter. **Be sure to keep this PIN number secure and with you at all times.**

Once your account has been activated, everything that you need to know to effectively use the system is in the **How to Center** tab in the **My Learning** page. Simply click **My Learning** on the left menu and select a topic by clicking the icon on the right of the screen. The topics available are either Flash videos (you will need speakers to hear these) or PDF files (these documents can be read online or printed). Remember to click the icon (the Flash symbol or the PDF symbol) on the right side of the screen to launch the topic.

Check-in with Affinity eHealth

You are required to check-in seven (7) days per week, Monday through Sunday (365 days a year), between the hours of 3:00 am to 5:00 pm for your testing notification. You may now choose to either check-in A) by phone or B) via computer at www.affinityehealth.com/cms/msbn.

A) To check-in by phone, dial **1-877-267-4304** and be prepared to enter your **10 digit PIN#** (see below for value), plus **month** and **year of birth**. (see below for value), then press 1 to Check-In.

B) To check-in via computer online go to www.affinityehealth.com/cms/msbn and enter your **username** and **password** you created during your Activation process. Once logged in, press the Check-In button.

Continued on back .....→

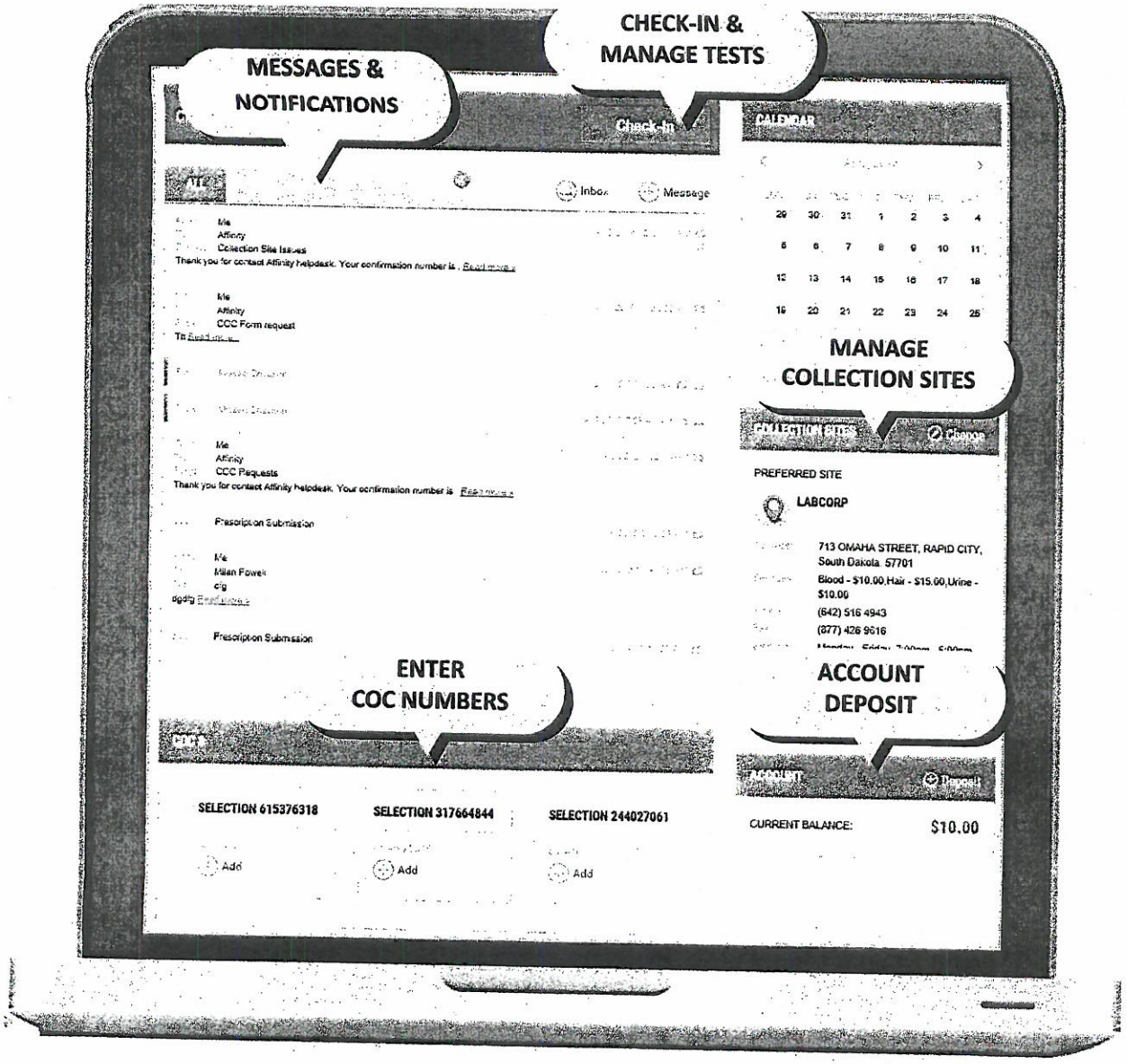
Enhanced Participant Experience

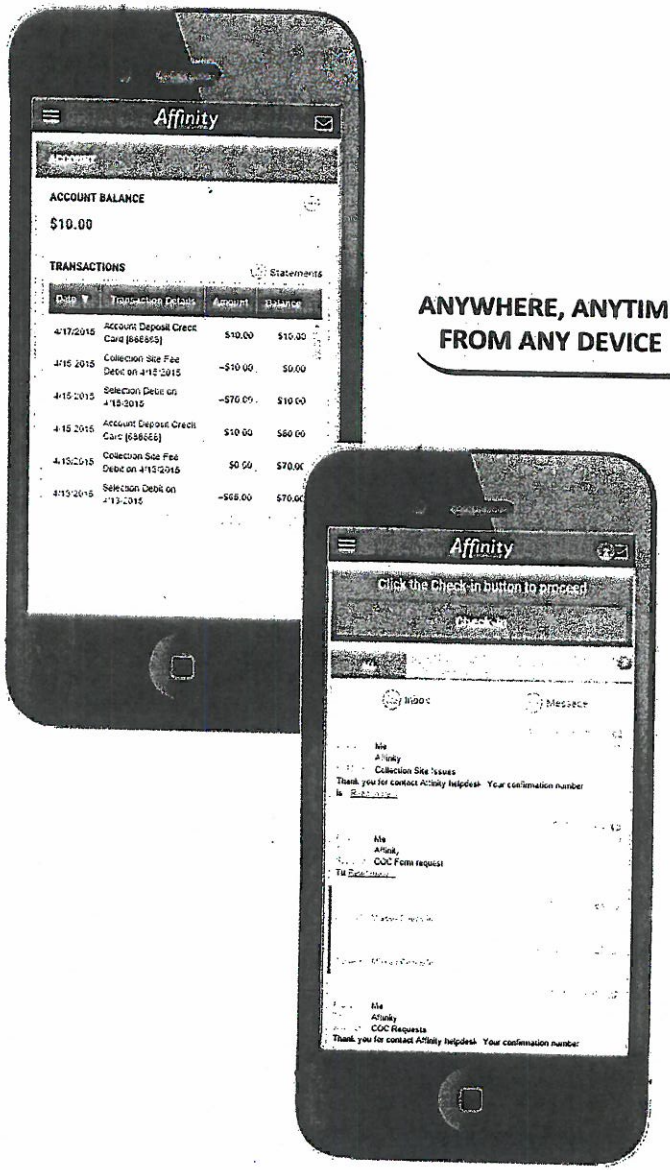
Quick Start Guide

Affinity eHealth.com

1 PARTICIPANT HOME PAGE:

Find everything you need to check-in, manage your drug tests, account, collection sites and messages—all on one page, in a few easy clicks, from any device.





ANYWHERE, ANYTIME FROM ANY DEVICE

Enhanced Participant Experience

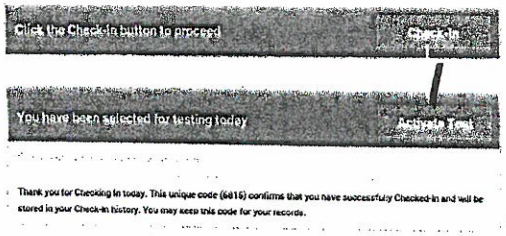
Quick Start Guide

Affinity eHealth.com

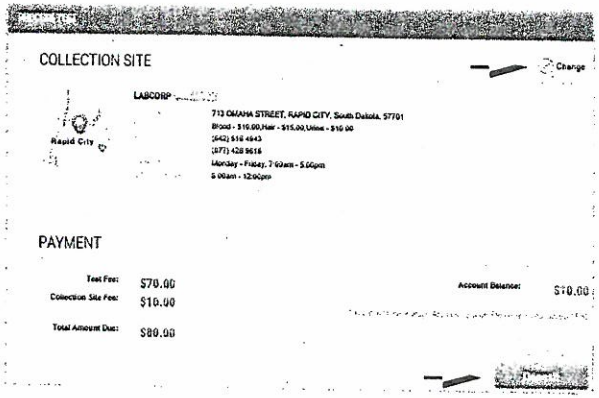
2 CHECKING-IN AND ACTIVATING A TEST:

Check-in, test activation and test details are all easily accessed from the top of the home page.

1. Click **Check-In,** easily accessed from the top of the home page. If you are selected for testing, click **Activate Test**, which now replaces the **Check-In** button.



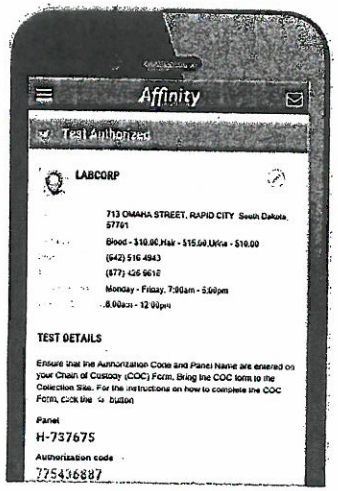
2. Change your collection site and deposit to your account (if you need to) — all directly from the **Process Test** window.



3. Click **Authorize** to process your test.

   Your test details, including authorization code, appear at the top of the home page, and remain conveniently displayed there on both desktop and mobile until your next check-in.

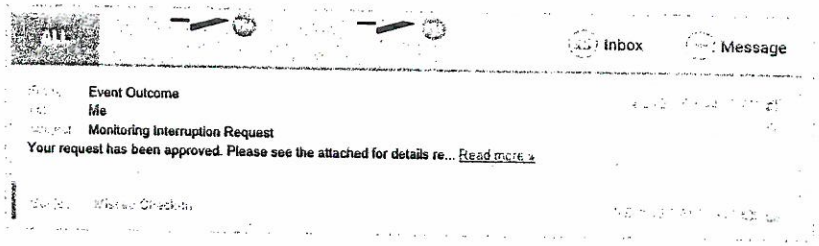
   Note: If you have a COC number, you can ensure it is recorded with your test details. Click the appropriate selection at the bottom of the home page, and type the number in the window that appears.



3 VIEWING AND ARCHIVING MESSAGES & NOTIFICATIONS:

View messages and notifications (formerly alerts), in one central location. Reduce the clutter of previously read items by sending them to your archive.

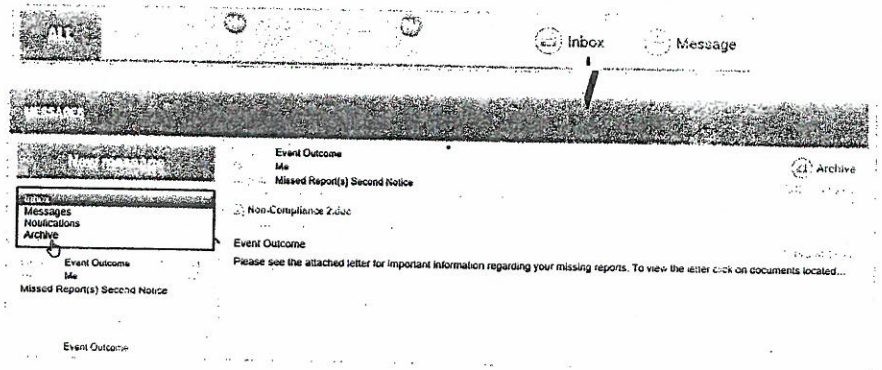
1. View your most recent message threads and notifications in the main body of the home page. Note your number of unread items highlighted on the **Messages and Notifications tabs.**



2. Click **Messages** to view recent message threads only.
   Read the content of a message thread by clicking Read more>>.
   Archive a message thread by clicking .

3. Click **Notifications** to view recent notifications only.
   Unread notifications appear in red. Click to mark them read, or archive them if you want to remove them from your active list altogether.

4. Click **+Message** to start a new message thread and send it to one or more recipients, or click **Inbox** to open your inbox where you can view all your messages and notifications, including those you have archived.



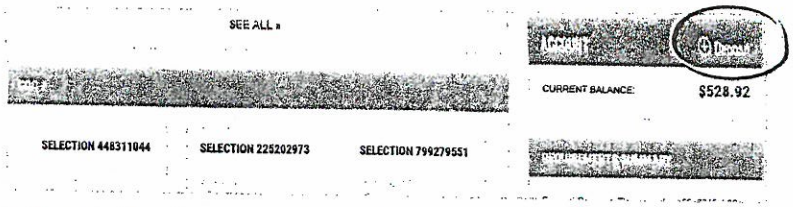
Enhanced Participant Experience
Quick Start Guide

Affinity eHealth.com

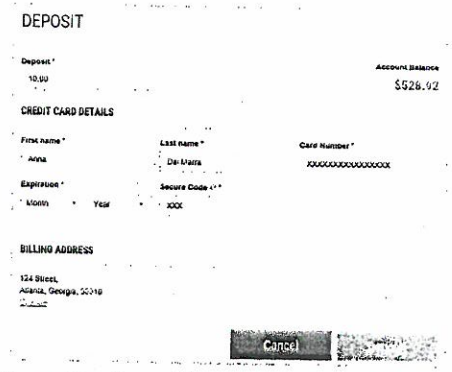
4 MAINTAINING YOUR ACCOUNT:

Deposit to your account at any time from the home page, or get full account details from the Compliance menu.

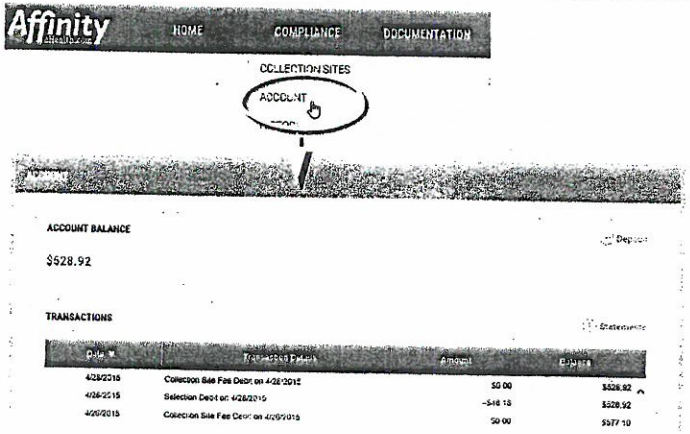
1. Scroll down the home page to the **Account** tile, and click **Deposit.**



2. In the window that appears, provide your payment details, including name, card number and billing address, then click **Deposit.**



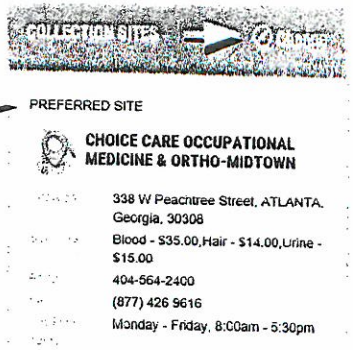
3. From the **Compliance** menu, click **Account** to access full account details.



5 MANAGING YOUR COLLECTION SITES:

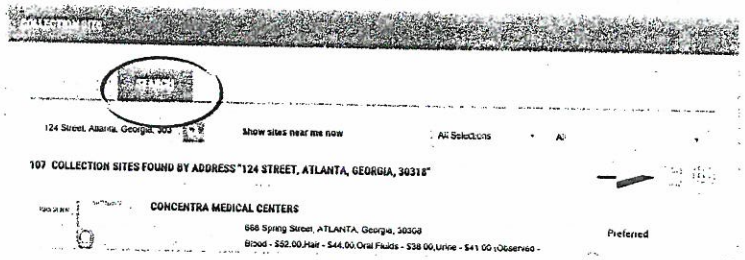
Maintain an unlimited number of sites, and flag one as preferred. Or take advantage of Affinity's geo-location capabilities, and find a site near you.

1. From the home page, view your current preferred site from the **Collection Sites** tile.



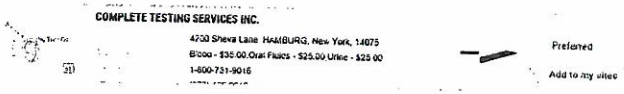
2. Click **Change** to update your list of sites, or to change your preferred site.

3. From the **Collection Site** page that now appears, find new sites and add them to your list by clicking **Search**. Toggle between List View and Map View using the icons on the right side of the page.



4. Search for sites by starting to type an address, city or zip code in the **Search** field, then select it from the drop-down list. Or check **Show sites near me now** to use Affinity's geo-location service to find a site close to you.

5. To change your preferred site, click **Preferred** to the right of your preferred site's details. To add a site to your list of sites, click **Add to my sites.**



Enhanced Participant Experience

Quick Start Guide

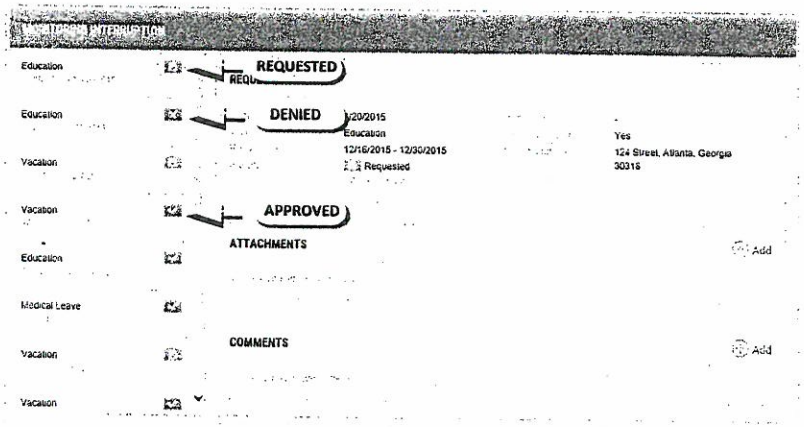
Affinity eHealth.com

6 REQUESTING A MONITORING INTERRUPTION:

Easily request a monitoring interruption, and view the status of previous requests, from the Documentation menu.

1. Click **Monitoring Interruption** from the **Documentation** menu.

2. On the page that appears, view the status of previous requests on the left, and selected request details on the right.

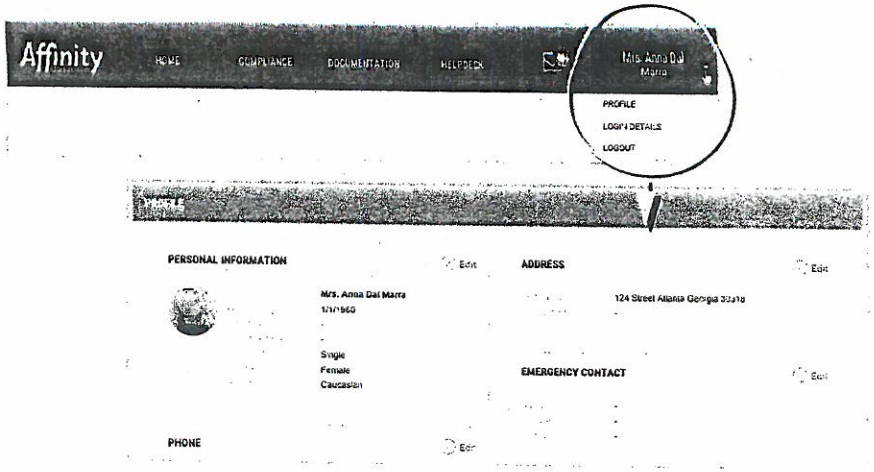


3. Add a new request by clicking **New Request**.

7 EDITING YOUR PROFILE AND LOGIN DETAILS:

Conveniently access your user profile and login details from the login drop-down, displayed at all times at the top of your page.

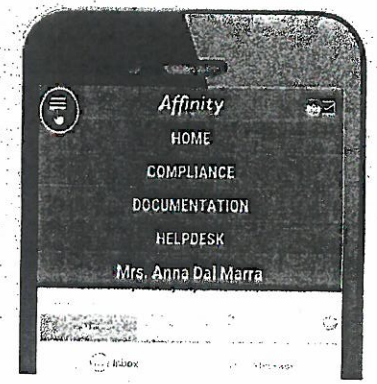
1. From the login drop-down, open your user profile by clicking **Profile**.



2. Access your login details by clicking **Login Details** from the login drop-down. If you choose to change your password, note the guidelines for creating a new password. Your password must contain:
   - 6 – 15 characters
   - 1 uppercase character/special character/number
   - No spaces

TIPS

- Conveniently access all the features described in this Quick Start Guide while on-the-go from your mobile device. Navigate from the home page, or click ☰ to display the menu drop-down.
- Return to the Home Page at any time on your desktop or mobile by clicking **Home** on the menu bar.
- Contact Affinity using the **Helpdesk** menu. Send an email by clicking **Contact Affinity** or find full Affinity contact details by clicking **Contact Details** from the **Helpdesk** menu. The Affinity Helpdesk is open 7 days a week, Monday to Friday, 6:30 am - 8:00 pm (ET), and weekends, Saturday and Sunday, 9:00 am - 5:00 pm (ET), including most federal holidays.

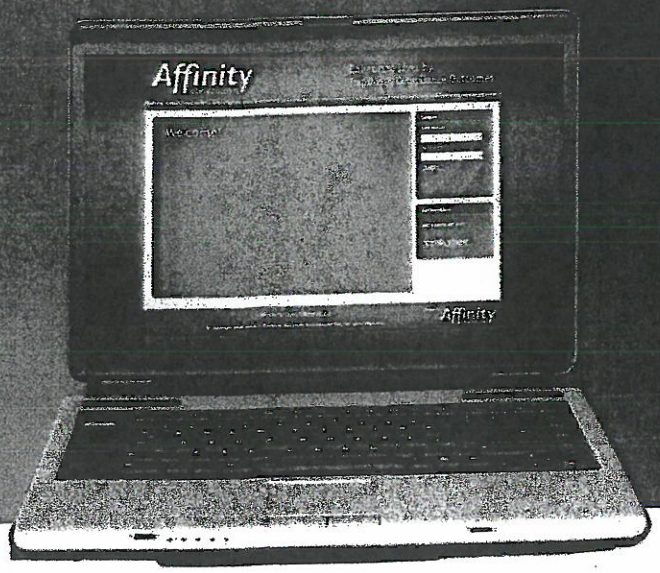


Affinity eHealth.com

Activation Guide

Welcome to **AffinityeHealth**. Your participation in the AffinityeHealth program is about to commence. To begin, you must activate your account online prior to your required start date.

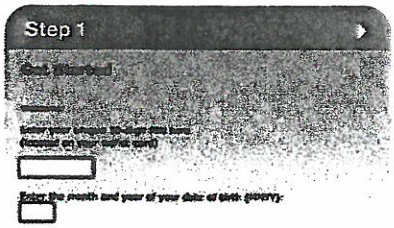
www.AffinityeHealth.com



6 Easy Steps to activate your account.

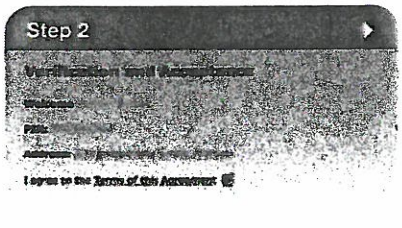
To use the **AffinityeHealth** compliance monitoring solution, a one-time activation process is required. Once activated, you can login to AffinityeHealth or call Client Support at **1.877.267.4304**.

To begin, go to the **www.AffinityeHealth.com** homepage, then click the Activate account button.

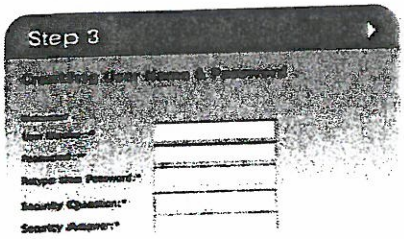


On the **Get Started** page, enter your PIN# in the space provided. You will find your PIN# in your welcome letter.

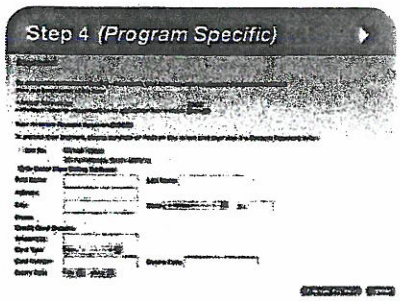
Enter your month and year of birth in a MMYY format. For example, if your birth date is January 1980, enter 0180. If the DOB we have on file in your welcome letter is incorrect, change it once you activate and log in to the system.



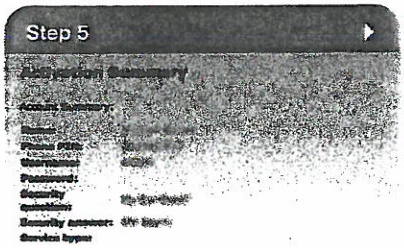
Carefully read the **Terms of Agreement** and, if acceptable, click the **"I agree to the Terms of this Agreement"** check box.



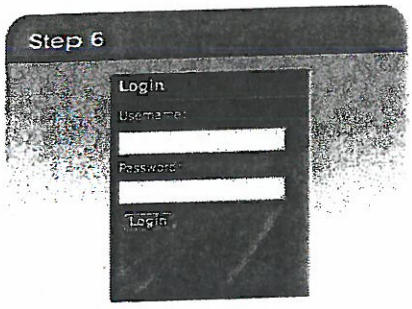
Select your Login details. Your **Username** and **Password** can be anything you choose. Make sure you write this information down and keep it in a safe place. Enter a **Security Question** and **Answer** for password retrieval.



Your program will determine a minimum amount of initial deposit to be used for future tests.



To complete your activation, click the **Activate** button on the Activation Summary page.



Once Activated, use your account credentials to login. After login, see **My Learning**, under **Tools** for tutorials which demonstrate system features.

You can contact **AffinityeHealth** online or by phone. Our client support representatives (CSR) will be happy to assist you with any issues you might encounter to ensure successful participation in your compliance program.

AffinityeHealth Help Line
Toll Free 1.877.267.4304

Affinity eHealth.com

Participant User Guide

2011/07/25

About this Guide

The Affinity eHealth (Affinity) Compliance Monitoring Solution (CMS) provides access to participants in monitoring programs. This user guide has been designed to provide detailed instructions for you to maximize your use of CMS. This guide provides an overview of Getting Started and details on how to process a test when selected.

Who is this Quick Reference Guide designed for?

This guide is designed to assist participants associated with programs that use CMS to help them understand the available features of CMS.

What's in it for me?

This guide will enable you to effectively utilize the system and ensure compliance tasks are completed. Within this guide, you will find instructions on how to:

- manage your online account
- manage your collection sites
- check-in
- obtain test details and complete the steps for getting tested
- manage your Chain of Custody (COC) Forms
- view your check-in history
- find more information about your compliance program

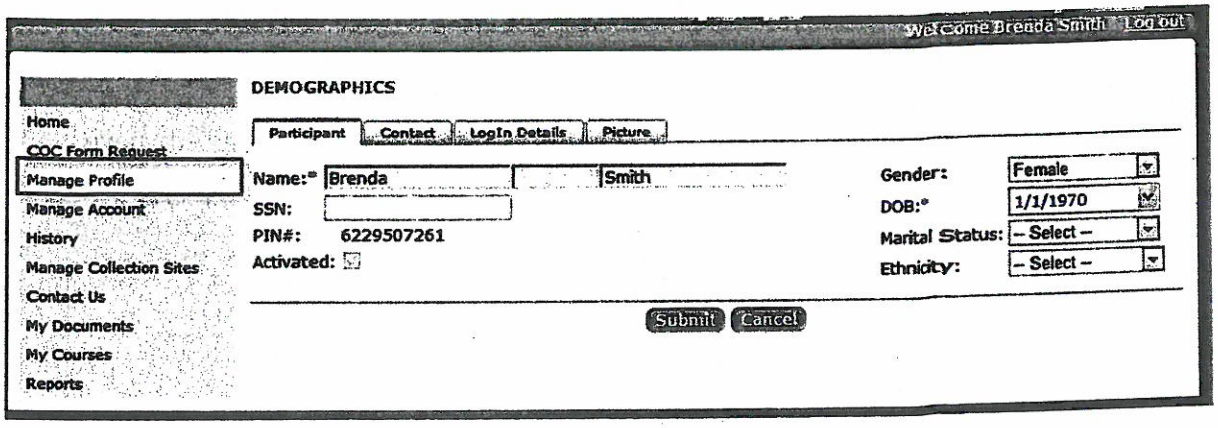
How long will it take me to go through this guide?

This guide covers all features and procedures available to manage your compliance. It will take you approximately 30 minutes to go through the entire guide. You can save time by jumping to the applicable sections. Each topic on an average may take you around 2 – 10 minutes to complete, depending on the length and scope of the topic.

Manage Personal Profile

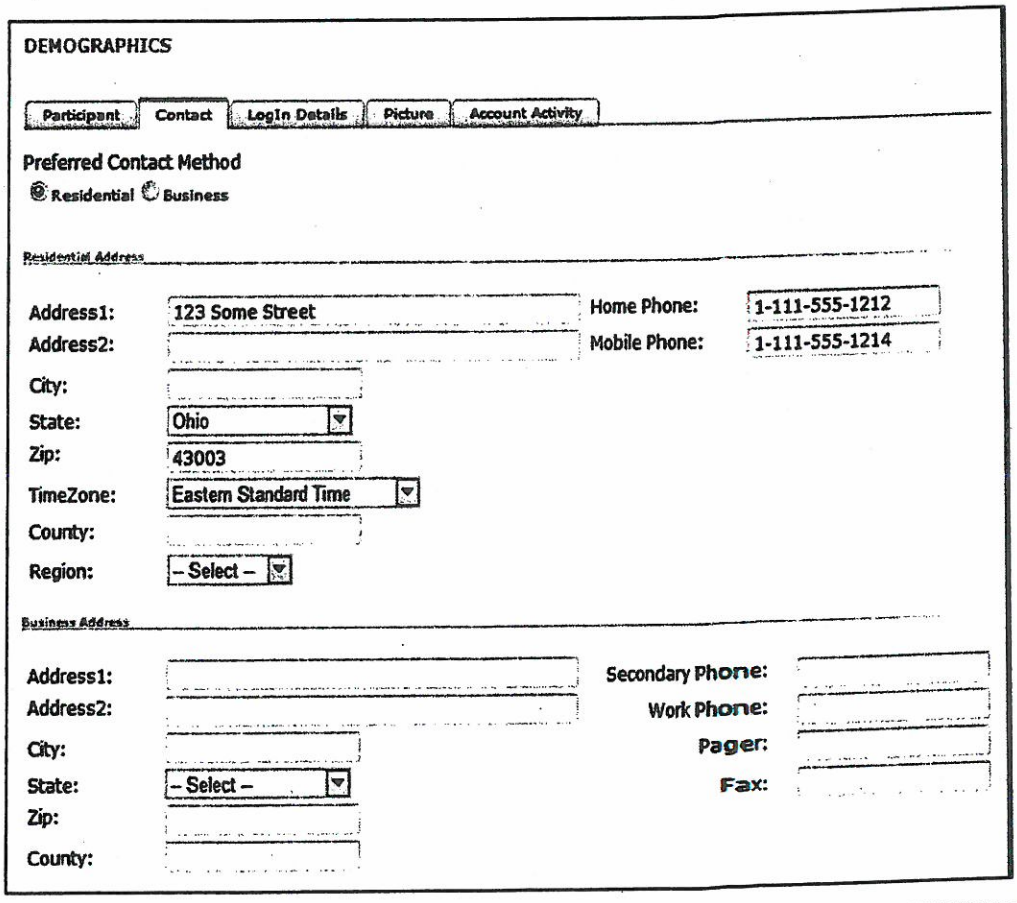
You can make modifications to your personal profile at any time. It is an important first step to ensure that the information in our system is correct.

To access your Personal Profile, click the **Manage Profile** link in the menu.

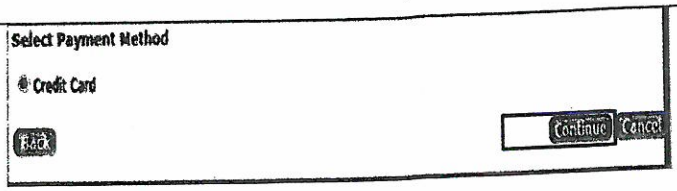


On the **Participant** tab, use the text fields and drop-down menus to add or modify your user profile. Since your date of birth (DOB) is used when you log into the IVR, it is very important that you ensure the correct information is entered in the DOB text field.

The **Contact** tab provides all of your contact information.



2) Click the radio button beside Credit Card and then click the **Continue** button to proceed to the next step.



3) Fill in your Credit Card Details:

a) type the dollar amount you want to deposit in the **Amount** field (typically $40-$100 + collection fee)

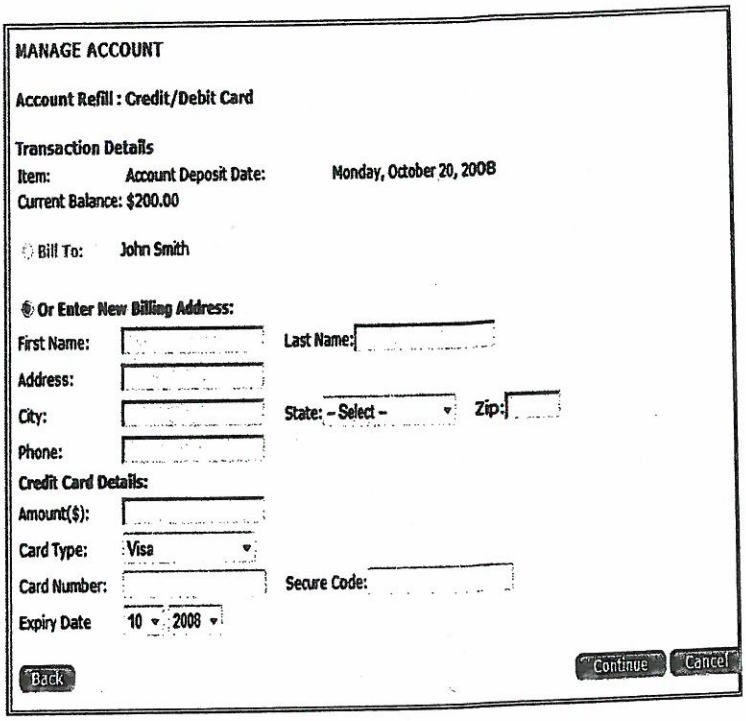
b) ensure the name on the credit card matches the billing information you insert into this screen

c) select the Card Type

d) type your Card Number

e) **you must** type your Secure Code found on the back of your card

f) select the Expiry Date (month and year of your card)



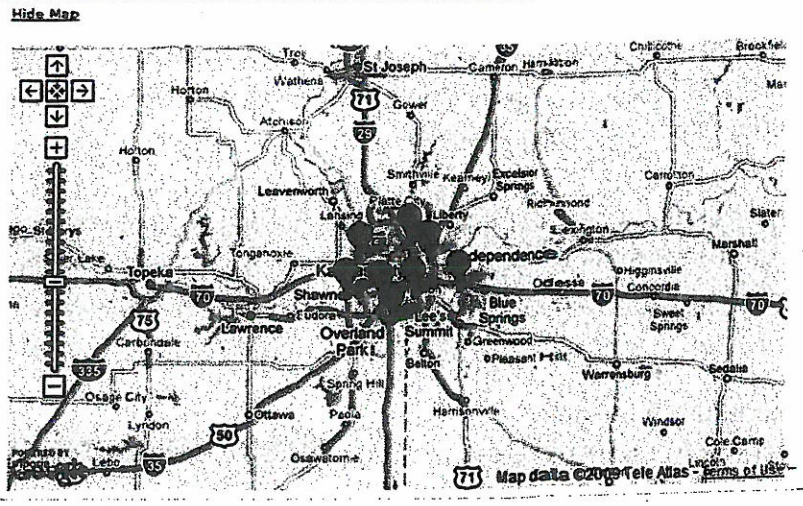
NOTE: This transaction will be processed on a secure server. Affinity does not store your Credit Card information.

4) In order to confirm the payment, click the **Continue** button.

NOTE: You are also able to deposit funds and check your account balance on the IVR phone system.

Zooming in on the map will limit the sites available to the specified location.

The letter on the map corresponds to the letter beside the site name on the Search Results list.



To obtain details from the search results list, click the name of the site.

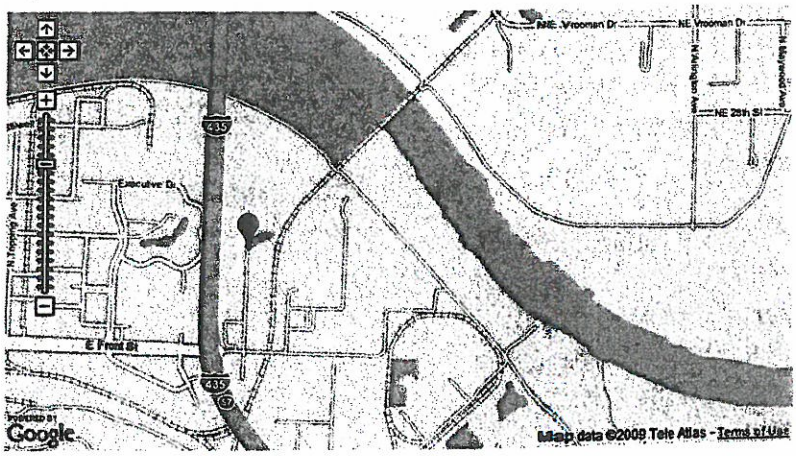
Search Results

Marker	Name	City	State	ZipCode
A	LABCORP	KANSAS CITY	Missouri	64118
B	LabCorp Services	KANSAS CITY	Missouri	64120
C	LabCorp Services	KANSAS CITY	Missouri	64132

Details are provided including the Map, Address, Phone Number, Hours of operation and the Cost for the site to collect the sample and send it to the lab(varies by site).

COLLECTION SITE DETAILS

Map



Name:	LabCorp Services
Address:	1706 N CORRINGTON AVE
City:	KANSAS CITY
State:	Missouri
Zip:	64120
Owner:	LabCorp
Phone:	816-483-1177
Fax:	816-483-5760
Hours:	M-F CLOSED LUNCH SAT HOURS, 8:00AM-4:30PM 12:30-1:30 8:00AM-12:00P
Cost:	.

COC Forms Available: No

Notes:

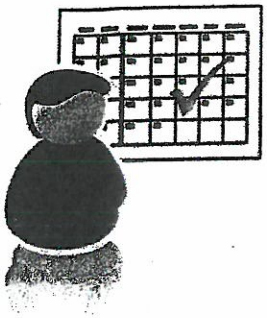
Make this my Preferred Collection Site: ☐ Submit Cancel

NOTE: To make this site your Preferred Collection Site, click the "Make this my Preferred Collection Site" check box and press Submit.

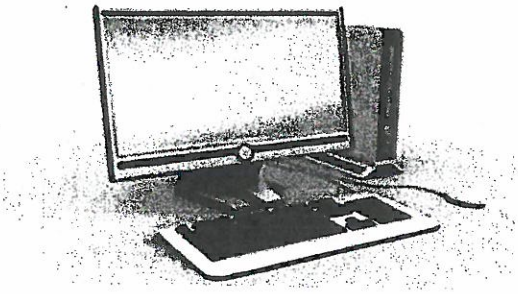
Daily Check-In

On the start date of your compliance program, you will be required to check-in to be notified of random test requirements.

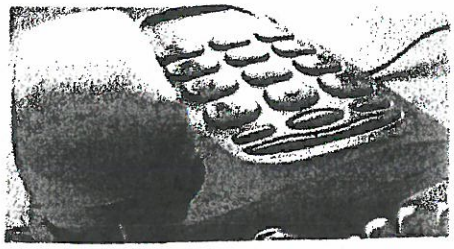
For Check-In requirements, please refer to the details enclosed in your Welcome Package.



Check-In can be performed either online or by phone(IVR).



OR



Testing Notification

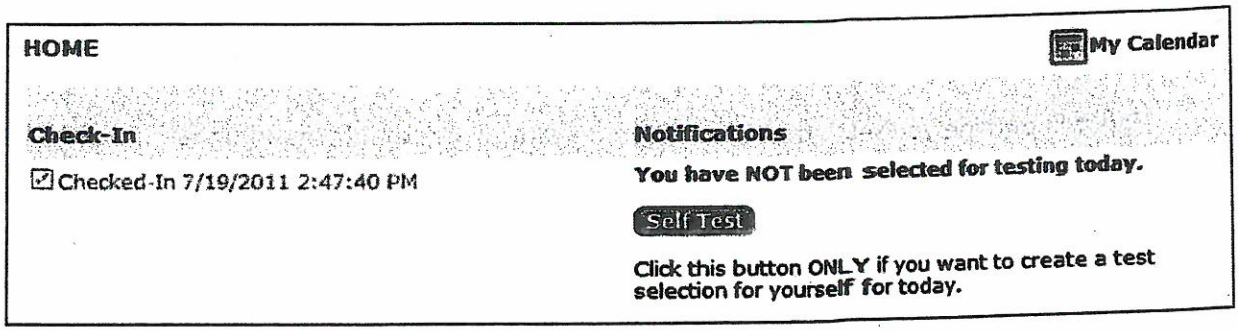
Regardless of the Check-In method used, there are two possible outcomes when completing a Check-In:

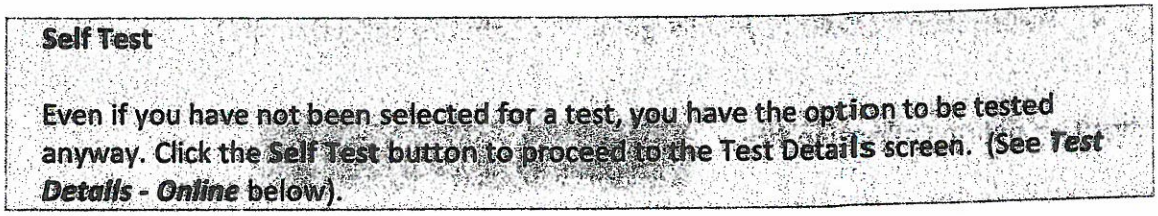
1. You ARE NOT selected for a test.
2. You ARE selected for a test.

If testing is required, the Test Details are immediately available with both Check-In methods. See the appropriate section below on how to process these details so you can provide your specimen.

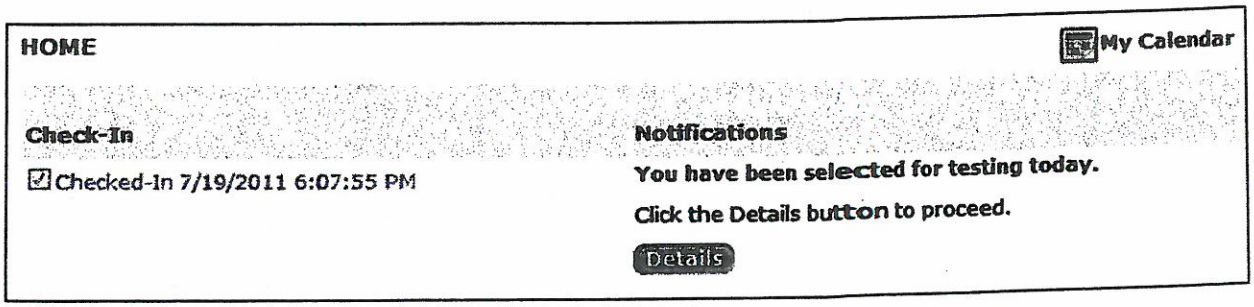
After clicking the **Check-In** button, you are notified of your requirement to test. There are two possible notifications presented:

1) **You have NOT been selected for testing today.**
   If you are not selected for a test, the system will display "You have NOT been selected for testing today." Your check-in is then recorded by the system.



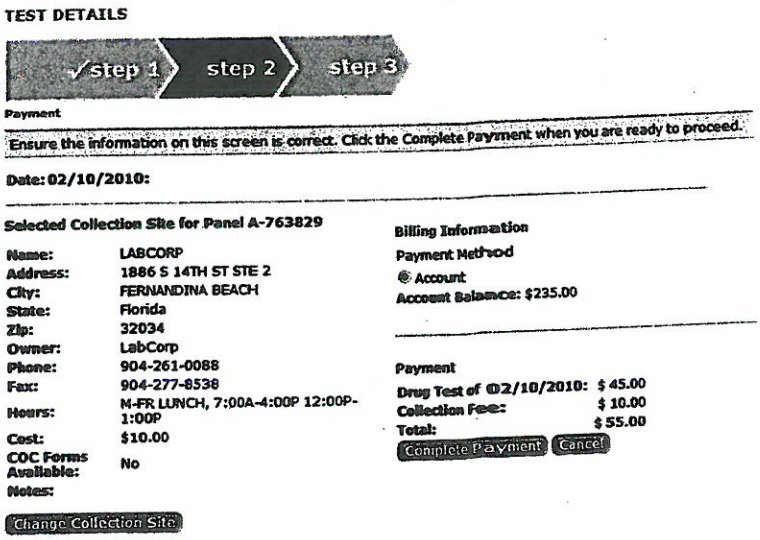


2) **You have been selected for testing today.**
   If you are selected for a test, the system will display the message "You have been selected for testing today." Your check-in is then recorded by the system and a Details button is displayed below the notification message.



Step 2 – Confirm Payment
Once you have confirmed your collection site, the next screen displays the cost of the test, the collection site fee for the site selected, and the total cost.

Your current **Account Balance** is also displayed. Click **Complete Payment** to Continue.



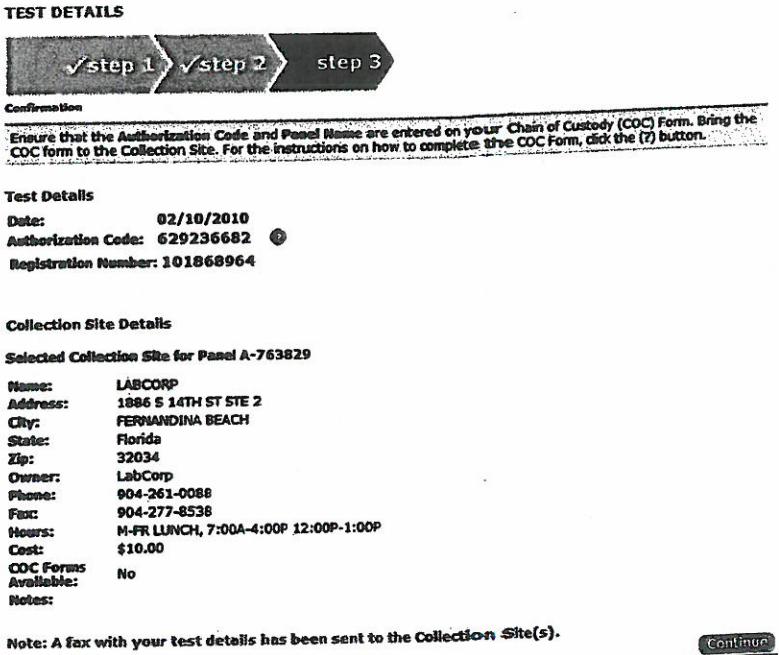
NOTE: If there are not enough funds in your account, select the **Manage Account** link from the navigation bar. After you have deposited sufficient funds in your account, you must return to the **Home** page and select the **Details** button again. Then repeat the selection process.

Step 3 – Confirmation of Test Details

This screen provides you with an **Authorization Code** and a **Panel Name**. You will need to enter this information on your COC form.

Click the **Continue** button to ensure you have the correct information for your test. **We recommend you take a printed copy to the collection site. To print this page, press Ctrl-P, select your printer and press the Print button.**

This completes the test details process.



Test Details – Phone (IVR)

For participants using the IVR phone system, if a test is required, you will be notified on the phone when you Check-In. You will have the option of obtaining your Test Details immediately on the phone.

NOTE: If you do not have a Preferred Collection Site selected you will NOT be able to obtain test details automatically over the IVR/phone system. You will need to go online or call Affinity at 1-877-267-4304 and leave a message for a Client Support Representative to call you. Either of these methods will allow you to update your Collection Sites.

NOTE: If you do not have a sufficient account balance to cover the cost of the test and the appropriate collection site fee you will need to add funds to your account. The IVR system provides you an option to do this.

The Test Details message will provide you with three important pieces of information that are critical for completing your test:

1. Authorization Code
2. Panel Name
3. Registration # (**ONLY** if going to a LabCorp collection site)

When you call, be prepared to write down and enter this information on the COC form.

NOTE: Your Preferred Collection Site on record will automatically be sent a fax with your information. Remember, you **MUST** go to the collection site specified as your preferred site. If you go to a site other than the one you chose in the selection process, Affinity will be instructed by the preferred site that you did not arrive for your test, which generates a "No Show" report on your test history in CMS.

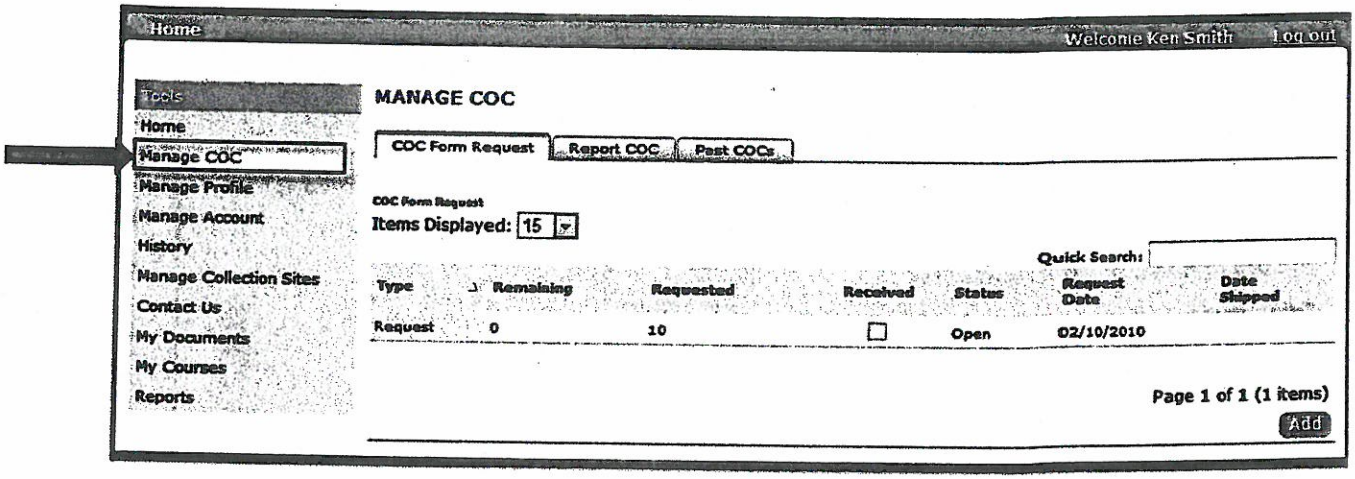
Please see the COC Form Completion section for detail on how to complete the COC form with the information provided.

COC Form Completion

For your convenience, you have been provided with several Chain of Custody (COC) Forms in your Welcome Package. Additional COC forms can be ordered at any time from your online account or by calling Affinity Client Support. It is important to note that these COC forms ARE NOT VALID without a unique Affinity Test Authorization Code and Test Panel Name properly filled out on the form. Forms received at the lab without a valid Authorization Code or Panel Name will be marked as "Test Suspended" until an Authorization Code and/or Panel Name are provided.

Managing COCs

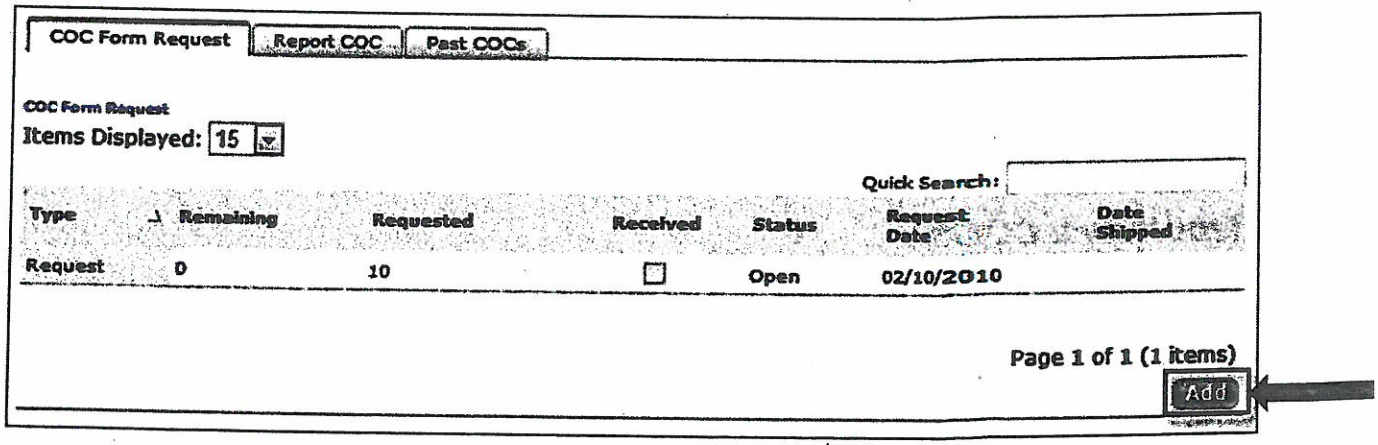
After you and the Lab have completed filling out the COC, the COC # on the form allows the system to confirm that the specimen has been donated and is used to track the specimen throughout the testing and final results stages. CMS provides you with the ability to manage your COC Forms, ensure that the number is logged in the system, and view past used numbers for your records. To manage your COC numbers and forms, click the **Manage COC** link on the menu.



Requesting COC Forms

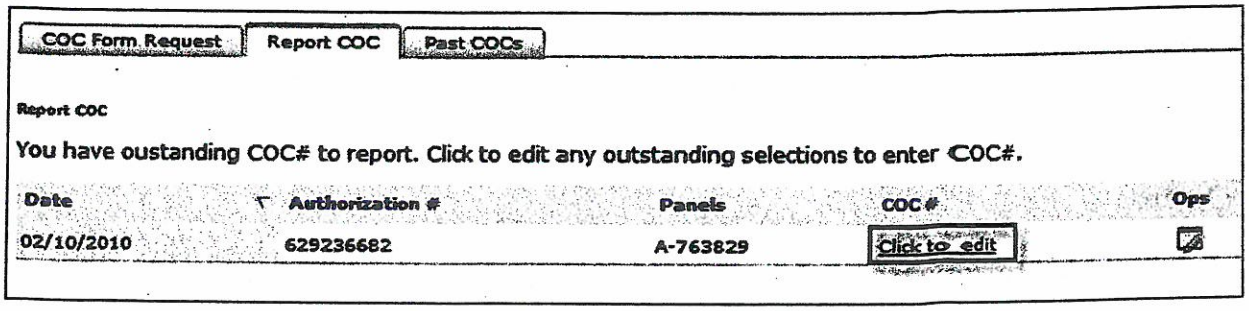
You have been provided with a set of COC Forms with your Welcome Package. If you run out of forms, you can order additional supplies by clicking Add on the COC Form Request tab.

The COCs will be mailed out within two working days and will take several days to arrive. Please ensure you have sufficient forms on hand to cover your testing needs for two months.



If the COC # is not available, you will see a record on the "Report COC" tab below and have the ability to report the COC number yourself.

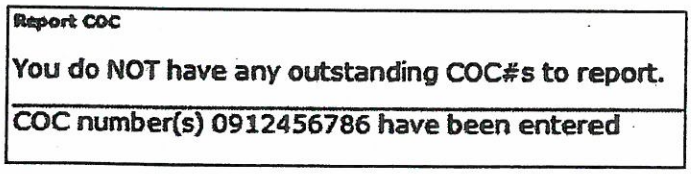
NOTE: You only see this record if the COC # has NOT been reported by other means



To enter the number, simply click on the "Click to Edit" link .

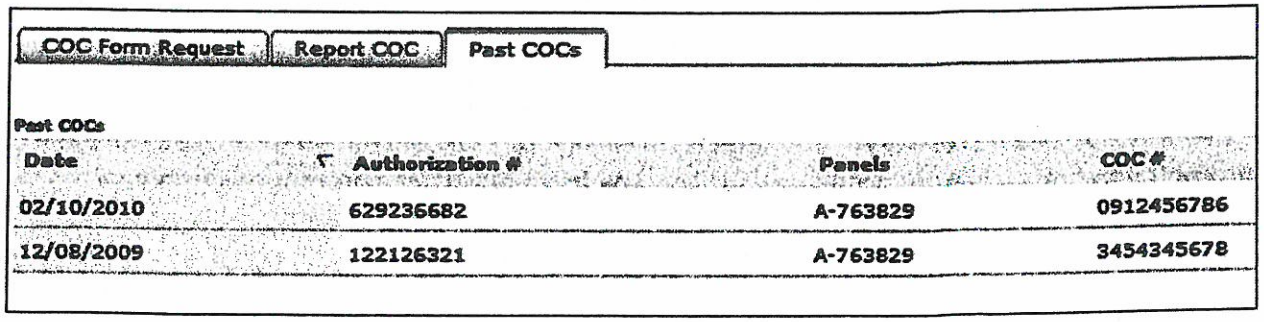
The record will display in edit mode and you will be able to type the COC#. Ensure the number is accurate and click the green check to submit.

A message will be displayed confirming your entry



Past COCs

You can view past used COC numbers at any time be clicking on the Past COCs tab.



The COC # used for all tests you have performed is displayed.

Frequently Asked Questions

How do I deposit money if I do not have access to a computer?
Call an Affinity Client Support Representative, and have a debit or credit card available.

What do I need to bring with me to the collection site?
You MUST BRING your COC form with BOTH the Authorization Code and Panel Name you received when you were notified for testing. To confirm your identity, the collection site will ask to see your photo ID or driver's license.

What if I can't provide funds for my Test Panel screening?
You must contact your Case Manager, and they will advise you further.

What if I don't own a debit or credit card?
You can pay by purchasing a VISA or Master Card Prepaid/Gift Card available at most Wal-Mart, Kroger's, or Walgreen stores. Follow normal online Account Management procedures described in this User Guide. You may also want to contact your bank to apply for a credit card for future use.

How much do Test Panel screenings cost?
Test Panel fees can range from approximately $40-$100 (plus Collection Site fee, which vary depending on which site you select). The cost of the collection site fee will be confirmed during the payment process.

When can I expect my credit card to be charged after I deposit funds?
Your credit card will be charged immediately.

Can I go to a collection site that is NOT in the Affinity Collection Site network?
Visiting a collection site that has not been approved by Affinity and is not in our list (therefore you were not able to find/select it during your Test Details process) will result in your test for that day being marked by the system as a "No Show". If you are aware of a collection site that is not in our network and you would like us to investigate adding them, please contact Affinity either online or by phone and provide the proposed Collection Site contact details. Until the site appears in our list you MUST go to an Affinity approved site that you have configured as your Primary Preferred site in CMS.

Can I change my preferred collection site?
Yes. You can change your preferred collection site by clicking the Manage Collection Sites link on the Navigation bar and selecting another approved site in our Collection Site Network.

Do I need to pay the collection site?
For most collection sites in our network the collection site fee is deducted at the same time as the Test Panel fee is deducted (during the completion of the Test Details process). You will see the amount on your confirmation page. You can find the cost of a Collection Site fee by selecting the site in the Collection Site Management page. Some sites are marked "Participant Pays at Site". For these sites, you will need to pay directly at the site at the time you donate your specimen.

Why do I need a PIN number?
In order to safeguard your online security, we have assigned individual PIN numbers to track your compliance. These are not Social Security Numbers.

If I have a PIN, why do I need an authorization code every time I am selected to test?
The authorization code verifies your payment, tracking and documents a specific Test screening.

How do I retrieve my PIN?
If you misplace/forget your pin, call Affinity Client Support at **1-877-267-4304**. Remember to store your PIN in a safe, secure yet accessible place.

How do I obtain additional Chain of Custody forms (COC)?
Call Affinity at **1-877-267-4304**, or click the COC Form Request link on the menu of your **Home** page in CMS. The COCs will be mailed out within two working days and will take several days to arrive. Please ensure you have sufficient forms on hand to cover your testing needs for two months.