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

Alternative Program for Substance Use Disorder Admission Application

Philosophical Overview

The Ohio Board of Nursing (Board) is charged with assuring the public that its licensees and certificate holders are qualified, safe and competent practitioners. Sometimes, the safeness and competence of the Board's licensees and certificate holders are brought into question because of behaviors and activities related to substance use disorder, warranting the Board's regulatory intervention. Although these behaviors and activities likely constitute grounds for Board disciplinary action, the Board recognizes that the underlying substance use disorder is a disease process that may be brought into remission with appropriate ongoing treatment.

The Board's Alternative Program for Substance Use Disorder (Program) is an alternative to disciplinary action for those licensees and certificate holders who have a substance use disorder, and who may be effectively treated for the disorder. When appropriate, the Board makes this confidential and strict monitoring Program available to its licensees and certificate holders, who take responsibility for and make progress in recovery, rather than proceeding with a public disciplinary action. This regulatory monitoring is accomplished by eligible licensees' and certificate holders' voluntary entry into the Program and compliance with all Program requirements and processes, which include the Program's placement of restrictions on practice. Program compliance is continually evaluated throughout the term of the Program. Practice restriction adjustments are made accordingly throughout the duration of the Program depending on compliance. The goal is that, during the Program term, the licensee or certificate holder will have been returned to an unrestricted practice while still under Program monitoring. Although successful Program completion does not guarantee the licensee or certificate holder's continued sobriety, it does indicate that the licensee or certificate holder has, for an acceptable amount of time, proven their ability to resume practice in accordance with the acceptable and prevailing standards of care by taking complete responsibility for their ongoing recovery.

Application Information

This is an application for admission to the Program. The information contained within the completed application is used to assist the Board in determining your Program eligibility. Two of the major Program eligibility requirements are that you hold a current valid Ohio license to practice nursing or dialysis technician or community health worker certificate, and that **within ten (10) business days of the date the application was mailed** the Board receives a temporary and voluntary surrender of your license or certificate (form included).

Additionally, you will need to have completed a substance use disorder evaluation/assessment that includes a complete physical and psychosocial evaluation performed by a healthcare professional with demonstrated expertise in substance use disorder, and submit documentation of this assessment, the resulting treatment plan, and ongoing treatment and recovery efforts. **Your application will not be considered complete until your evaluation/treatment records are received. You must submit a completed application to the Program within sixty days of the date the application was mailed by the Board. Completion and submission of this application does not guarantee Program admission**.

If, after review of your application, you are deemed ineligible for Program admission, you will be notified by mail.

Determination of Program eligibility will also require the Program to communicate with other individuals and entities. Therefore, it will be necessary that you sign and submit the enclosed waivers giving the Program authorization to receive and release information from and to your employers, probation officers, law enforcement agencies, peer assistance programs, and any treatment and healthcare practitioners.

Please be advised that the Program is required by law to report felony conduct to law enforcement. However, the reporting of felony conduct to law enforcement may not include the disclosure of information that is protected by law, such as drug treatment records, or other medical or mental health records. Also be advised that the Program is a unit of the Board, and information and records related to your application to and participation in the Program will be accessible to the Board and its members, employees and legal counsel.

Alternative Program Participant Requirements

If you are determined eligible for Program admission, you will be required to sign an Alternative Program Participant Agreement (Agreement) after which you will be known as a Program Participant. The Agreement establishes a minimum Program length of four years. The Agreement is a legally binding document. Failure to comply with the terms and conditions of the Program may result in termination of your Program participation and subsequent formal disciplinary proceedings against your license or certificate. The Agreement sets forth all of the Participant's responsibilities, which include, but are not limited to, the following:

1. Abstaining from the use of alcohol, drugs of abuse, and controlled substances, except for time limited drugs of abuse and controlled substances prescribed for purposes of medication-assisted treatment in accordance with state law, or prescribed for other health purposes by a treating practitioner;
2. undergoing random drug testing administered by the drug testing company designated by the Board (Participants are financially responsible for the costs associated with the drug testing);
3. compliance with the substance use disorder treatment plan;
4. signing additional waivers to provide for the Program's ongoing communication with entities involved with your recovery and legal resolutions;
5. attending support, peer group, or twelve-step meetings;
6. providing personal reports;
7. facilitating the sending of reports by other entities as applicable, such as probation officers, employers, healthcare providers, etc;
8. timely submitting paperwork/documents; and
9. communicating with your assigned Monitoring Agent on an ongoing basis.

Please direct any questions concerning this application or any required information to alternative@nursing.ohio.gov. Submit your completed application to: Ohio Board of Nursing, Alternative Program for Substance Use Disorder, 17 South High Street, Suite 660, Columbus, OH 43215-3466.

Licensure/Administrative

Your name as it appears on your license or certificate: _____

Current address, email, and telephone number:_____

_____

List all other current or former names you have used: _____

Ohio Nursing License Number: _____

Ohio Dialysis Technician or Community Health Worker Certificate Number: _____

PLEASE NOTE:
All correspondence will be mailed to your address of record with the Board.

Disciplinary History

1. Has there been any prior disciplinary action taken by the Ohio Board of Nursing against your license? ___Yes ___No If yes, please explain.

_____
_____
_____
_____
_____

2. Has there been any denial of licensure or certification, or disciplinary action taken or pending by another state or jurisdiction concerning your licensure or certification in that state or jurisdiction? ___Yes ___No If yes, please explain.

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_____
_____
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_____

3. Have you, or are you, participating in another agency or jurisdiction's alternative or diversion program? ___Yes ___No If yes, list the agency or jurisdiction, the dates of your participation, and whether or not you successfully completed the program.

_____
_____
_____
_____
_____

Substance Use Disorder

1. Do you have a substance use disorder? Yes ____ No ____

2. Have you been diagnosed as having a substance use disorder by a qualified healthcare provider? **If yes, please provide the name, address and telephone number of the qualified healthcare provider**.

_____
_____
_____
_____

3. Are you currently abstaining from alcohol and drugs? Yes ____ No ___

   a. When was your last use of alcohol? _____

   b. When was your last use of a narcotic, controlled substance, drug of abuse, or mind-altering drug/substance? _____

4. Are you currently attending support group meetings? Yes ___ No ___ If yes, please describe.

_____
_____
_____
_____

5. Do you have a sponsor or peer support recovery specialist? Yes ____ No ____

6. Are you receiving ongoing concurrent mental health, or medical care or treatment? Yes ___ No ___ If yes, please describe.

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7. List **all** substance use disorder treatment providers and dates of treatments you have undergone, attended and/or completed, beginning with the most recent.

Date Provider Completed: yes/no

_____
_____
_____
_____

Legal or Criminal Proceedings

1. List all arrests, convictions, treatment and/or intervention in lieu of convictions, diversion, guilty pleas, no contest pleas, and/or probations or community control for all crimes you have incurred, including the county or jurisdiction in which the arrest, conviction, treatment and/or intervention in lieu of conviction, diversion, guilty plea, no contest plea, and/or probation or community control occurred. Include the dates and outcomes.

Drug/Alcohol Use History

1. Please provide a historical narrative describing your use of prescribed or non-prescribed narcotics, controlled substances, drugs of abuse, mind-altering substances, and/or alcohol. Be specific as to the medications, drugs, and/or substances that you used.

2. Please describe the events leading to your present application seeking entry into the Alternative Program and indicate whether or not there was another agency or law enforcement involvement in the events/situation.

(Please continue response(s) on a separate sheet if necessary.)

I have completed and submitted the following forms and documentation as required and/or applicable: (Please place your initials below to indicate your provision of the completed form or documents.)

____ **Form A-1 (required): Initial Voluntary Temporary License/Certificate Surrender**

____ **Form A-2 (required): Release Concerning Public Access of Web-based Licensure Verification**

____ **Form B (required): Waiver for Exchange of Information to Determine Eligibility for the Alternative Program for Substance Use Disorder**

____ **Substance Use Disorder evaluation/assessment and resulting treatment plan (required)**

____ **Form C (required): Secondary Contact Form**

____ **Form D (required): Licensure History Form**

____ **Form E (required): Current Medication Report**

____ **Form F (required): Current Employer List**

____ **Form G (required): Treating Healthcare Practitioner List**

____ **Form H (required): Substance Use Disorder Treatment/Aftercare/ or Mental Health treatment**

I affirm that all information provided in this application is true and correct, that my submission of this application represents my intent to enter the Alternative Program for Substance Use Disorder, and that this application will not be considered by the Board if it is incomplete. I understand that I will be notified by the Program upon its receipt of my completed application.

_____ _____
Applicant Signature Date