INSTRUCTIONS

Instructions:
1. This form must be completed, in full, by **authorized prescriber only**.
2. By signing this form, you verify the information listed is correct and **that you have been informed that this individual is monitored through random drug screens**.
3. List all prescription medications.
4. Licensee is responsible for making sure the prescriber provides this completed form to the Missouri Board of Nursing within five (5) business days of the prescription date.
5. Contact the Director of Compliance with questions.

LICENSEE INFORMATION

<table>
<thead>
<tr>
<th>Name of Licensee/Patient</th>
<th>License number</th>
</tr>
</thead>
</table>

Participant in:
- [ ] Alternative Program
- [ ] Intervention Program
- [ ] Probationary Licensee
- [ ] Not Currently in a Board Program

I acknowledge the participant has explained to me that he/she is being monitored by the Board related to the following substances:
1. 
2. 
3. 
4. 

PRESCRIPTION INFORMATION

<table>
<thead>
<tr>
<th>DATE OF PRESCRIPTION</th>
<th>NAME OF MEDICATION</th>
<th>DOSAGE AND FREQUENCY</th>
<th>AMOUNT PRESCRIBED</th>
<th>NUMBER OF REFILLS</th>
<th>REASON FOR MEDICATION</th>
<th>CONTROLLED SUBSTANCE?</th>
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</tbody>
</table>

For controlled substances, indicate the length of time the medication is to be used:

Date prescription should be disposed or completed:

It is recommended that a licensee receive no more than a one month supply of any controlled medication in a single prescription. A Prescription Identification Form must be completed with each refill.

Your signature represents that you have discussed alternatives with the licensee and that, in your opinion, there is no effective alternative.

Authorized Provider’s Signature
Date

Authorized Provider’s Name
Office Phone Number

Facility Name
Fax Number

Office Address

ORIGINAL MUST BE RETURNED BY PRESCRIBING PROVIDER