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## Re-entry to Nursing Practice Packet

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Participant Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Date Packet Submitted: \_\_\_\_\_ Date Packet Received: \_\_\_\_\_

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## **Introduction**

This packet has been developed to assist you in your request to return to licensed nursing practice in the most time efficient and effective manner while providing information to assist Board staff in determining your readiness to return to safe practice. Submission of the packet does not automatically result in your approval to return to work.

Packet review by Board staff:

**If the documentation is sufficient/complete:**

You will be notified in writing, via mail or email, of a determination of your readiness to re-enter practice.

**If the documentation is insufficient/incomplete:**

You will be informed of the reason the packet is incomplete. This may or may not involve a review of the entire packet. Once the packet is determined to be incomplete, you will not be eligible to re-petition for a minimum of one (1) month; therefore, you are urged to CAREFULLY review each section for completeness prior to submission.

**Please note:** Illegible documentation will result in return of the packet.

## Item 1: Information About You

<b>SUBSTANCE USE HISTORY</b>		
DATE OF SOBRIETY	DATE LAST USED/ABUSED DRUGS	DATE LAST DRANK ALCOHOL
LIST YOUR SUBSTANCE(S) OF CHOICE AND ABUSE		
1.	2.	3.
DESCRIBE THE INCIDENTS/ACTIONS WHICH RESULTED IN PARTICIPATION IN THE ALTERNATIVE PROGRAM		
HOW DID YOU OBTAIN SUBSTANCES WHEN YOU WERE USING? CHECK ALL THAT APPLY.		
<input type="checkbox"/> PRESCRIPTION ABUSE	<input type="checkbox"/> WRITING OWN RX	<input type="checkbox"/> DOCTOR SHOPPING
<input type="checkbox"/> DIVERSION	<input type="checkbox"/> ALTERING OWN RX	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> STREET PURCHASE	<input type="checkbox"/> CALLING IN FRAUDULENT RX	
DESCRIBE IN DETAIL YOUR METHOD OF OBTAINING THE SUBSTANCES YOU USED		
NOW THAT YOU ARE SUBSTANCE-FREE, HOW WOULD SOMEONE KNOW IF YOU ARE USING AGAIN?		

**HEALTH STATUS**

DESCRIBE ANY CURRENT ACUTE OR CHRONIC MEDICAL PROBLEMS

**EMPLOYMENT**

ARE YOU CURRENTLY EMPLOYED?

- Yes
- No

IF YOU ARE CURRENTLY EMPLOYED, IS YOUR EMPLOYMENT:

- Healthcare related (licensed)
- Healthcare related (non-licensed)
- Non-healthcare related

**ADDITIONAL INFORMATION**

IS THERE ANYTHING YOU WISH TO SHARE THAT HAS NOT BEEN ASKED?

**AFFIRMATION**

The statements in this document and the items attached are true in every respect. I have not suppressed any information that would affect this packet for review regarding my return to work.

SIGNATURE

DATE

## Item 2: Evidence of Treatment Participation

### INSTRUCTIONS

On facility letterhead stationary, have each counselor or therapist provide documentation of your participation in substance use disorder treatment or other required therapy. The documentation should include:

- a. Date began treatment
- b. Date began aftercare
- c. Dates and number of missed sessions with reasons
- d. Plans for any missed sessions
- e. Current treatment schedule
- f. Summary of your progress to date and assessment of recovery

Have the counselor(s) submit the above information to:

Missouri State Board of Nursing  
 Attn: Director of Compliance  
 P.O. Box 656  
 Jefferson City, MO 65102  
 Fax: 573-522-2143  
 Email: [nursingcompliance@pr.mo.gov](mailto:nursingcompliance@pr.mo.gov)

Please complete the following for each counselor/therapist you are working with. You may attach additional pages, if needed.

NAME OF PROVIDER	TITLE
NAME OF FACILITY	
PHONE NUMBER	HOW LONG SEEN BY PROVIDER
REASON BEING SEEN	
NAME OF PROVIDER	TITLE
NAME OF FACILITY	
PHONE NUMBER	HOW LONG SEEN BY PROVIDER
REASON BEING SEEN	
NAME OF PROVIDER	TITLE
NAME OF FACILITY	
PHONE NUMBER	HOW LONG SEEN BY PROVIDER
REASON BEING SEEN	

### **Item 3: Required Evaluation and Evidence of Compliance**

#### **INSTRUCTIONS**

1. Provide a comprehensive psychological diagnostic assessment, provided by a doctorate level provider with at least three years post licensure experience with substance use disorders and dependence, indicating the licensee is safe to practice nursing.
2. Sign a release with the provider so that they may discuss your case with Missouri State Board of Nursing staff.
3. Have the provider submit a signed copy of the evaluation on his/her letterhead.
4. Submit evidence of compliance with all recommendations made by the provider.

PHYSICIAN NAME

DATE EVALUATED

WERE RECOMMENDATIONS MADE?

No                       Yes – If yes, please list:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

FOR EACH RECOMMENDATION ABOVE, EXPLAIN HOW YOU HAVE COMPLIED AND SUBMIT SUPPORTING DOCUMENTATION

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## Item 4: Evidence of Participation in a Twelve-Step Program

### **INSTRUCTIONS**

Answer the questions below.

Have your sponsor submit a signed letter outlining the following:

- a. The frequency of your twelve-step meetings
- b. Frequency of contact with you including face-to-face and telephone
- c. What step you are currently working
- d. His/her length of sobriety
- e. Description of your twelve-step activities and his/her general impression of your recovery status
- f. Their relationship to you

He/she should submit the letter to:

Missouri State Board of Nursing

Attn: Director of Compliance

P.O. Box 656

Jefferson City, MO 65102

Fax: 573-522-2143

Email: [nursingcompliance@pr.mo.gov](mailto:nursingcompliance@pr.mo.gov)

DATE BEGAN TWELVE-STEP PROGRAM	FREQUENCY THAT YOU ATTEND MEETINGS
DO YOU HAVE A HOME GROUP? <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, please List name of home group: _____	
FIRST NAME OF SPONSOR	HOW LONG YOU HAVE HAD THIS SPONSOR
HOW OFTEN YOU MEET WITH SPONSOR	FREQUENCY YOU SPEAK WITH SPONSOR (EXCLUDING MEETINGS)
WHAT STEP YOU ARE ON	NUMBER OF SPONSORS IN THE PAST THREE (3) YEARS
HAVE YOU PARTICIPATED IN ANY OTHER SELF-HELP RECOVERY? <input type="checkbox"/> No <input type="checkbox"/> Yes – If yes, please describe below the function of the program and how it benefited your recovery. _____ _____ _____	

## Item 5: Relapse Prevention Plan

### **INSTRUCTIONS**

Please submit your relapse prevention plan by completing the following:

LIST YOUR INDIVIDUAL TRIGGERS.

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DESCRIBE ANY SITUATIONS WHICH WOULD BE HIGH RISK FOR YOU.

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DESCRIBE YOUR PLAN OF ACTION TO MINIMIZE ACTING ON ANY OF THESE IN A RELAPSE MODE.

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PROVIDE A BREIF DESCRIPTION OF YOUR SUPPORT SYSTEM.

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DOCUMENT ANY INSIGHTS INTO THE EVENTS THAT BROUGHT YOU TO THE MONITORING PRORAM AND THEIR IMPACT ON PATIENT CARE AND COWORKERS.

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IDENTIFY CONCERNS ABOUT POTENTIAL WORK SETTINGS AND THE IMPACT ON RECOVERY.

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DESCRIBE DESIRED AREAS OF PRACTICE AND POTENTIAL EMPLOYERS/EMPLOYMENT SETTINGS.

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IDENTIFY HOW YOU PLAN TO MAINTAIN YOUR RECOVERY PROGRAM ONCE YOU RETURN TO PRACTICE.

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## Item 6: Criminal Record Information

### **INSTRUCTIONS**

Please answer the questions below.

HAVE YOU BEEN CONVICTED OR DO YOU HAVE PENDING ANY OF THE FOLLOWING:

Driving While Impaired/Driving Under the Influence       Pending       Previous Conviction       Never Charged or Convicted

Misdemeanor       Pending       Previous Conviction       Never Charged or Convicted

Felony       Pending       Previous Conviction       Never Charged or Convicted

If you have a criminal record and/or you have pending charges, please contact the Director of Compliance to determine if the matter is already on file. If not on file, you will be required to submit a notarized statement and supporting documents.

### **Item 7: Submission of Criminal Background Check**

If your license has been suspended for six months or more, you must submit a criminal background check (fingerprint). The criminal background check is valid for one (1) year.

Criminal background check required six (6) months from \_\_\_\_\_ if you have not yet been approved to re-enter practice.

To complete the criminal background check, go to [www.machs.mo.gov](http://www.machs.mo.gov) and register using the 4 digit registration number of 0001 (three zeroes followed by a one). **The name, date of birth and social security number you use to register with MACHS must match the same information on file with the board.** If it does not, you may be required to complete this process again at your expense. After you register, follow the instructions on their website to complete the fingerprint background check.

## Item 8: List of All Current Health Care Providers

### INSTRUCTIONS

Complete the information below for all current health providers. Specify a primary care provider.

Have each provider listed below provide you with a letter on his/her letterhead stationary stating the following:

- a. Awareness of your history of substance use disorder, specific substance(s) of choice/abuse and how you obtained the substances
- b. Diagnoses for which he/she is treating you
- c. All medications prescribed – dosage, reason for prescribing and plans to continue
- d. The primary care provider must identify himself/herself as such and list all medications you are taking to include those prescribed by other providers
- e. Telephone number of provider
- f. If you are receiving Methadone, an in-depth explanation must be submitted by an addictionologist regarding the decision to use this method of treatment. A description of the Methadone Clinic with letters from your counselor and prescribing physician must be submitted.
- g. If you are employed by and/or related to any of your health care providers, a statement identifying the relationship is required.

**All required letters must be written by the healthcare provider. Do not provide the individual with a letter composed by you for his/her signature.**

### PRIMARY HEALTH CARE PROVIDER

PROVIDER NAME	SPECIALTY
PRACTICE NAME	
PRACTICE ADDRESS	
DATE ESTABLISHED AS A PATIENT	TELEPHONE NUMBER

### DENTIST

PROVIDER NAME	
PRACTICE NAME	
PRACTICE ADDRESS	
DATE ESTABLISHED AS A PATIENT	TELEPHONE NUMBER

### OTHER

PROVIDER NAME	SPECIALTY
PRACTICE NAME	
PRACTICE ADDRESS	
DATE ESTABLISHED AS A PATIENT	TELEPHONE NUMBER

<b>OTHER</b>	
PROVIDER NAME	SPECIALTY
PRACTICE NAME	
PRACTICE ADDRESS	
DATE ESTABLISHED AS A PATIENT	TELEPHONE NUMBER
<b>OTHER</b>	
PROVIDER NAME	SPECIALTY
PRACTICE NAME	
PRACTICE ADDRESS	
DATE ESTABLISHED AS A PATIENT	TELEPHONE NUMBER
<b>OTHER</b>	
PROVIDER NAME	SPECIALTY
PRACTICE NAME	
PRACTICE ADDRESS	
DATE ESTABLISHED AS A PATIENT	TELEPHONE NUMBER
<b>OTHER</b>	
PROVIDER NAME	SPECIALTY
PRACTICE NAME	
PRACTICE ADDRESS	
DATE ESTABLISHED AS A PATIENT	TELEPHONE NUMBER



**Item 10: Authorization and Release of Information**

I, \_\_\_\_\_, authorize the Missouri State Board of Nursing to release information contained in my file to members of the Missouri State Board of Nursing for consideration of re-entry/reinstatement of my license.

Further, I authorize the Missouri State Board of Nursing to receive any and all information pertinent to the Board’s determination of my ability to return to safe and competent practice.

This authorization will serve as a release to any and all health care providers, employers, etc. to provide the Missouri State Board of Nursing with information necessary, in their sole discretion, to make the decision for re-entry/reinstatement.

This information is released for the purpose of determining eligibility for returning to licensed practice and that purpose only. Any other use is prohibited.

\_\_\_\_\_  
Signature of Licensee

\_\_\_\_\_  
Date

This form is to be signed by you and returned with the completed Re-Entry to Nursing Practice packet to allow the Board to review your information in consideration of your petition to return to practice.