



## Alternative Program for Chemical Dependency/Substance Use Disorders 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 chemical dependency, warranting the Board's regulatory intervention. Although these behaviors and activities likely constitute grounds for Board disciplinary action, the Board recognizes that the underlying chemical dependency is a disease process that may be brought into remission with appropriate ongoing treatment.

The Board's Alternative Program for Chemical Dependency/Substance Use Disorders (Program) is an alternative to disciplinary action for those licensees and certificate holders who are chemically dependent, and who may be effectively treated for the chemical dependency. 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 their chemical dependency 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 the participant's compliance with all Program requirements and processes, which include the Program's placement of restrictions on the participant's practice. Participant 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 the participant's compliance, which reflects their ongoing recovery efforts. The goal is that, during the Program term, the participant 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 chemical dependency 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** you submit to the Board a temporary and voluntary surrender of your license or certificate (form included).

Additionally, you will need to have completed a chemical dependency/substance use disorders evaluation/assessment that includes a complete physical and psychosocial evaluation performed by a healthcare professional with demonstrated expertise in chemical dependency/substance use disorders, 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. remaining clean and sober;
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 all treatment/aftercare plans;
4. signing additional waivers to provide for the Program's ongoing communication with entities involved with your recovery and legal resolutions;
5. attending 12 step or similar support group 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](mailto:alternative@nursing.ohio.gov). Submit your completed application to: Ohio Board of Nursing, Alternative Program for Chemical Dependency, 17 South High Street, Suite 400, Columbus, OH 43215-7410.**

**Licensure/Administrative**

Your name as it appears on your license or certificate: \_\_\_\_\_

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. If your address has changed, please complete the enclosed Address Change Form.**

**Disciplinary History**

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

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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? If yes, please explain.

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

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**Chemical Dependency**

1. Do you have a chemical dependency? Yes \_\_\_\_ No \_\_\_\_
2. Have you been diagnosed as having a chemical dependency/substance use disorder by a qualified healthcare provider? **If yes, please provide the name, address and telephone number of the qualified healthcare provider.**

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3. Are you currently clean and sober? 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. Describe your current 12 Step or other support group meeting attendance.

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5. Do you have a 12 Step sponsor? Yes \_\_\_\_ No \_\_\_\_

6. Are you receiving ongoing concurrent mental health, or medical care or treatment? If yes, please describe.

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

Date	Provider	Completed: yes/no
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**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 Chemical Dependency/Substance Use Disorders**
- \_\_\_ **Chemical Dependency/Substance Use Disorders 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): Current Chemical Dependency/Substance Use Disorders Treatment/Aftercare/Mental Health information**
- \_\_\_ **Letter from 12 Step or other support group sponsor (as applicable)**
- \_\_\_ **Documentation of 12 Step meeting or other support group attendance (as applicable)**

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 Chemical Dependency/Substance Use Disorders, 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