MARYLAND BOARD OF NURSING
DISCIPLINE AND COMPLIANCE DIVISION
4140 PATTERSON AVENUE
BALTIMORE, MARYLAND 21215-2254
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Email Address: mbon.nursingdiscipline@maryland.gov

TREATMENT PROGRAM / PROVIDER VERIFICATION

Date:____________________

Nurse/Certificate Holder: __________________________________ **License#:**____________

Name of Program: ______________________________
Provider's License #:____________________________
Phone: ____________________________

Treatment Since: _________________________
(Month / Year)

Diagnosis: For the above named individual, please provide your current, full Axis I–V diagnoses:
Axis I: _______________________________
Axis II: ______________________________
Axis III: _____________________________
Axis IV: _____________________________
Axis V: ______________________________

Type of Treatment:
Inpatient Residential Intensive Outpatient Outpatient Aftercare Individual

Attending Support Group Meetings, i.e. AA, NA, etc.: ____Yes ____No ___# Of Mtgs.
Number of appointments scheduled: ____________ **Number attended:** _________
Dates attended:____
Dates Missed:____
If missed, why and what are your concerns: ____
____

Current Treatment Goals (list all):
____
____

Participant Progress with Treatment Goals (provide details for each):
____
____
____

FOR PROBATION ORDERS ONLY		
Do you have a complete copy of the client's Nursing Board Order(s)?		
Yes, from client? ☐	***Yes, from Board/website?*** ☐	***No?*** ☐
FOR CONSENT AGREEMENTS (Impaired Practice Program Participants) ONLY		
Do you have a complete copy of the participant's agreement with the committee?		
Yes, from client? ☐	***Yes, from Board/website?*** ☐	***No?*** ☐

Medications prescribed to client, by you, or to your knowledge: Yes ______ No ______ Unsure____
List All:

____

Drug screens conducted by you since last report?
Drug screens conducted at your direction?
Drug screens random & observed?
Drug screens follow chain of custody?
Any positive drug screen results since last report?
Positive drug screen results confirmed?

Description:

____

As far as you are aware, is the participant practicing his/her health profession? Yes No

Do you have any concerns about the participant's ability to practice his/her health profession? ☐ Yes No
Comments: ____
____

Do you agree to complete required monthly / quarterly reports, if appropriate? _____Yes _____No

THIS FORM MUST BE SUBMITTED BY THE TREATMENT PROVIDER

For Office Use Only

Date Received: ________________________ **Case Manager: ___________________________________**