OKLAHOMA BOARD OF NURSING
2915 N. Classen Blvd., Suite 524
Oklahoma City, OK 73106

Telephone: 405/962-1800
Facsimile: 405/962-1819
Website: www.nursing.ok.gov

NURSE'S INITIAL MEDICATION REPORT

RESPONDENT/NURSE NAME: _____
(Print Name)

To be completed by the nurse within 10 days of receipt of the Board Order. Report all medication(s) being taken to include prescription and over-the-counter medications. If you have any questions, please call the Oklahoma Board of Nursing at (405) 962-1827.

PRESCRIPTION AND/OR OVER-THE-COUNTER ("OTC") MEDICATION(S)

(Please print and complete all boxes as appropriate.)

Date Prescribed and/or OTC Taken	Name of Medication	Dosage	Frequency	Number Prescribed	Detailed Purpose	Name of Prescribing Healthcare Provider ("Prescriber")
Example: **9/16/13**	**Percocet**	**7.5 mg 1 tab**	**Every 4-6 hrs as needed**	**30 tabs**	**left hip pain**	**John Doe, M.D.**
Example: **9/17/13**	**Tylenol PM**	**500mg/25 mg 1 tab**	**Bedtime 3 times per week**	**OTC**	**sleep**	**OTC**
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

I declare and affirm that the information documented on this form is true, complete and correct. I understand that any false or misleading information shall be cause for the nurse's appearance before the Board.

_____ _____
(Respondent/Nurse signature) Date

Please complete in the designated online compliance system, mail, hand-deliver or fax (405) 962-1819 to the Board office. Please be advised that a verbal report will NOT be accepted.

Please refer to the Board's Body Fluid Testing Guidelines when completing the Nurse's Initial Medication Report.