

PEER ASSISTANCE PROGRAM
2901 N. Classen Blvd. Ste. 101
Oklahoma City, OK 73106

www.nursing.ok.gov

OKLAHOMA BOARD OF NURSING
405/525-2277
Fax 405/525-0350

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**APPLICATION FOR APPOINTMENT
PEER ASSISTANCE COMMITTEE**

Please complete and return with **resume and two letters of reference** to:

Peer Assistance Program
2901 North Classen, Suite 101
Oklahoma City, OK 73106
Attention: Jenny Barnhouse, DNP, RN

Name: _____

Address: _____

Telephone: _____
(Home) (Work)

E-Mail Address: _____

Type of License, Registration &/or Certification	State or other License/Certification Authority	Number	Expiration Date

Employer: _____

Address: _____

Telephone: _____

Title or Position: _____

Employment Dates: From _____ To _____

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Describe Duties and Responsibilities:

Clinical Experience (last 5 years): _____

Educational Preparation: _____

Describe specific experiences, education and/or other qualifications which contribute to your expertise in chemical dependency: _____

Briefly discuss your interest in participating on the Peer Assistance Committee:

APPOINTMENTS TO THE PEER ASSISTANCE COMMITTEE

Members of the Peer Assistance Committee are appointed by the Oklahoma Board of Nursing from applications for a term of three years. Committee members are reimbursed for expenses incurred in discharge of their official duties in accordance with the State Travel Reimbursement Act.

The committee has the following responsibilities:

- (a) determine licensee's acceptance into the program,
- (b) develop with licensee a contract for program participation,
- (c) meet with licensee on a specified basis to monitor and determine progress,
- (d) determine successful completion of the program,
- (e) determine termination from the program for failure to comply,
- (f) report all terminations to the Board.

Members of the committee shall have expertise in chemical dependency and the composition of the committee shall be:

- (a) at least three members,
- (b) at least one member who has certification/licensure in addictions,
- (c) at least one recovering person, and
- (d) the majority to be currently licensed nurses.

Please indicate below which qualification(s) you meet by completing the appropriate information and attaching to your application. This information will be utilized in ensuring the committee composition is met.

_____ ANCB Certification
Certificate Number _____
Expiration Date _____

_____ LADC/CADC
Certificate Number _____
Expiration Date _____

_____ Recovering Person
Sobriety Date _____

_____ Licensed Nurse
Biennial Number _____
Expiration Date _____

Any application with a State Agency for an appointive position is subject to the Open Records Act.