PEER ASSISTANCE PROGRAM OKLAHOMA BOARD OF NURSING
2901 N. Classen Blvd., Ste101 (405)525-2277
Oklahoma City, OK 73106 Fax: (405) 525-0350
www.ok.gov/nursing

PEER ASSISTANCE PROGRAM APPLICATION

NAME (as it appears on nursing license): _____
First Middle Last

☐LPN ☐RN ☐CNP ☐CNM ☐CRNA ☐CNS

LIST ALL STATES OF LICENSURE, LICENSE NUMBERS and STATUS OF LICENSE:

_____
_____
_____
_____

OTHER ACTIVE PROFESSIONAL LICENSES AND STATES: _____
_____
_____

EMPLOYMENT

START WITH PRESENT EMPLOYER
AND WORK BACK PREVIOUS THREE EMPLOYERS

NAME	DATES OF EMPLOYMENT	JOB TITLE	SPECIALTY AREA	REASON FOR LEAVING

Why are you applying to the Peer Assistance Program today? _____
_____
_____
_____
_____
_____
_____

Do you have an abuse and/or addiction problem with drugs and/or alcohol? ☐YES ☐NO

If accepted into the Peer Assistance Program, what do you hope to achieve? _____

_____

_____

_____

_____

_____

Have you been convicted of a felony or are you currently charged with the commission of a felony?

☐YES ☐NO If yes, please describe:

_____

_____

_____

_____

_____

AFFIDAVIT

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT FALSIFICATION OF THIS INFORMATION IS GROUNDS FOR DISMISSAL FROM THE PEER ASSISTANCE PROGRAM.

SIGNATURE: _____

DATE SIGNED: _____

STATISTICAL DATA

THE INFORMATION REQUESTED BELOW IS OPTIONAL AND WILL BE USED FOR STATISTICAL PURPOSES ONLY. THE INFORMATION WILL NOT BE USED IN ANY WAY TO DISCRIMINATE AGAINST ANY APPLICANT.

DATE OF BIRTH ☐ / / **NUMBER OFCHILDREN** ☐ **AGES OF CHILDREN**

☐ ☐ ☐

SEX: ☐MALE ☐FEMALE

MARITAL STATUS: ☐SINGLE ☐ MARRIED ☐DIVORCED ☐SEPARATED ☐WIDOWED

RACE/ETHNIC GROUP: ☐ CAUCASIAN ☐AFRICAN- AMERICAN

☐HISPANIC ☐ASIAN/PACIFIC ISLANDER ☐AMERICAN INDIAN

☐ NATIVE ALASKAN

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APPLICATION TO THE PEER ASSISTANCE PROGRAM AGREEMENT:

I, _____, am making application to the Peer Assistance Program. I understand to be considered for entry into the Peer Assistance Program I must agree to cease nursing practice until such time as the Peer Assistance Committee agrees that I am ready to safely resume nursing practice. I also understand failure to cease nursing practice may be grounds for denial of entry into the Program. My signature below indicates my agreement.

_____ _____

Applicant's signature Date

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Information Sheet:

NAME (as it appears on nursing license): _____
First Middle Last

ADDRESS: _____

City _____ State_____ Zip_____

HOME PHONE: ☐☐☐-☐☐☐-☐☐☐☐

WORK PHONE: ☐☐☐-☐☐☐-☐☐☐☐

CELL PHONE: ☐☐☐-☐☐☐-☐☐☐☐

OTHER CONTACT PHONE: ☐☐☐-☐☐☐-☐☐☐☐

SOCIAL SECURITY NUMBER: ☐☐☐ - ☐☐ - ☐☐☐☐

EMERGENCY CONTACT INFORMATION:

NAME: _____

RELATIONSHIP: _____

PHONE NUMBER: ☐☐☐-☐☐☐-☐☐☐☐