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

Oklahoma Board of Nursing
(405) 525-2277
Fax: (405)525-0350

MEDICATION LOG
(To be completed by the participant)

Case Manager: (circle) Debbie Hensley Erica McArthur

I, _____ (please print), have taken the following medications.

Date:	Time:	Medication/Dose:	Reason for use:	if RX Amount remaining	Prescriber
___/___/___	_____	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____	_____
___/___/___	_____	_____	_____	_____	_____

(Attach additional sheets if necessary)

List alternative measures attempted to relieve symptoms, prior to taking medication: _____

_____

_____

I certify that I have not worked within 24 hours of taking any medication, which is or could potentially be mind altering, addictive, or intoxicating.

_____ _____
Signature Date

This form must be received in the program office within 72 hours of the date and time on the first medication line above. It may be faxed to (405) 525-0350