NURSE’S 72-HOUR MEDICATION REPORT

RESPONDENT/NURSE NAME: ______________________________________
(Print Name)

To be completed by the nurse within 72 Hours of 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.)

<table>
<thead>
<tr>
<th>Date Prescribed and/or OTC Taken</th>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Number Prescribed</th>
<th>Detailed Purpose</th>
<th>Name of Prescribing Healthcare Provider (“Prescriber”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: 9/16/13</td>
<td>Percocet</td>
<td>7.5 mg 1 tab</td>
<td>Every 4-6 hrs as needed</td>
<td>30 tabs</td>
<td>left hip pain</td>
<td>John Doe, M.D.</td>
</tr>
<tr>
<td>Example: 9/17/13</td>
<td>Tylenol PM</td>
<td>500mg/25 mg 1 tab</td>
<td>Bedtime 3 times per week</td>
<td>OTC</td>
<td>sleep</td>
<td>OTC</td>
</tr>
</tbody>
</table>

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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 72-Hour Medication Report.