

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

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

PRESCRIBER MEDICATION REPORT

RESPONDENT/NURSE NAME: _____
 (Print Name)

Please complete the form below. **Please send the completed form directly to the Oklahoma Board of Nursing office. The completed form must be mailed or faxed by the Prescriber's office only.** If you have any questions, please call the Oklahoma Board of Nursing Compliance Registered Nurse at (405) 962-1818.

PRESCRIPTION INFORMATION (Please print and complete all boxes.)

Date of Prescription	Name of Medication	Dosage	Frequency	Number Prescribed	Number of Refills	Detailed Reason Prescribed
<i>Example:</i> 9/16/13	Percocet	7.5 mg 1 tab	every 4-6 hrs as needed	30 tabs	None	Left hip pain
1.						
2.						
3.						
4.						
5.						

I have been informed this nurse is being monitored by the Oklahoma Board of Nursing. I declare and affirm that the information documented on this form is true, complete and correct.

 Prescriber Name (Please Print)

 Prescriber Signature

 Prescriber Office Phone Number

 Date

I, _____ hereby authorize _____
 to disclose to the Oklahoma Board of Nursing, including staff and Oklahoma Board of Nursing Board members, any and all information relating to medical treatment which may be requested.

 Respondent/Nurse signature

 Date

 Witness signature

 Date