Program for Recovering Nurses
5530 W Emerald St
Boise, Idaho 83706
Office – (208) 323-9555 Toll Free – (800) 386-1695 Cell – (208) 891-4726
An Alternative to Disciplinary Action Program offered by the Idaho Board of Nursing

YEARLY UPDATED PRESCRIPTION DRUG LIST

This form is to be filled out by any practitioner who is prescribing you medications.
The Completed form must be mailed or faxed by the practitioner's office.

_____
(Printed Participant's Name)

Prescription Date	Type of Medication	Quantity and Dosage Prescribed/Number of Refills	Reason for Medication

_____ _____
Practitioner's Name (Please print) Business Name (If applicable)

_____ _____
Business Address Business Phone/Fax

I have been informed that this patient is involved in a monitoring program. I understand that his/her drug(s) of choice is/are: _____ .

I have been informed that this patient is involved in a monitoring program. I understand that he/she has a mental health diagnosis of: _____.

_____ _____
Practitioner's Signature Date