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These are your master forms. Please make copies as needed.
If you need more forms, please access our website www.tpapn.org
**ASSESSMENT FORM**

Print name _____________________________________ Case Number___________ Case Manager _____________________________________

Assessor, please:

☐ Ensure that nurse has provided you with a signed copy of the TPAPN consent form

☐ Fax a copy of the signed consent form to TPAPN

☐ Contact TPAPN Case Manager if you have questions

**Instructions:** This form is to be used by nurses considering participation in the Texas Peer Assistance Program for Nurses (TPAPN). This form is to be completed by any health professional that provides an assessment and/or treatment. Assessor and participant should retain copies. Please complete the following information and send to TPAPN.

This is to verify that (print nurse’s name) __________________________________________ was assessed on _______________________

- ☑ Mental Illness    - and/or -    ☑ Substance Use Disorder

**Psychiatric Diagnosis/impression:** ________________________________________________________________

Psychiatric treatment plan: ☑ Inpatient (date admitted/duration):________________________ ☑ Outpatient (date admitted/duration):________________________

- ☑ Medication Management (frequency):_______________ ☑ Individual Therapy (start date/frequency/name of therapist):________________________

Please list medications currently prescribed: ________________________________________________________________

**Substance Use Disorder (SUD) Diagnosis/impression:** ________________________________________________________________

Specify treatment recommendations: ☑ A&D Education ☑ Inpatient ☑ Outpatient ☑ Relapse Prevention ☑ Individual Therapy ☑ Other (please explain): ________________________________________________________________

Frequency of sessions: _________ x per week _________ x per month Length of stay (specify number of) days: _________ weeks: _________ months: _________ years: _________ Comments: ________________________________________________________________

Date admitted to SUD treatment facility/hospital: _________ Facility name: _____________________________________ Phone: _____________

**ASSESSOR NAME & CREDENTIALS (PRINT): ________________________________________________________________**

ASSESSOR SIGNATURE: ________________________________________________________________ Date: _______________________________

Facility name (PRINT): _________________________________________________________________________________

Address: __________________________________________ City: ________________________ State: _______ Zip: _____________

Phone: __________________________________________ Fax: __________________________________________

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*C/o Texas Nurses Foundation, 8501 N. MoPac Expy., Ste. 400 • Austin, TX • 78759 • 1-800-288-5528 • FAX 512/467-2620 • www.tpapn.org* 

TPAPN 10/14
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN TPAPN AND HEALTHCARE PROVIDER

NOTE: This authorization/consent form ("Authorization") is to be used only for exchange of information between TPAPN and healthcare providers.

I understand a condition of my participation in the Texas Peer Assistance Program for Nurses ("TPAPN") is that I authorize TPAPN to use and disclose my Protected Health Information ("PHI") to my health care providers. I further understand that if I add or change providers, that I will need to execute additional authorizations. Nurses who decline to sign this Authorization or such additional authorizations are not eligible to participate in TPAPN.

I, (print name) ___________________________, authorize (name of participant) __________________________ to use and disclose my PHI for purposes other than treatment, payment, or health care operations. I specifically authorize TPAPN or TPAPN’s designated employee(s) to disclose my PHI, as identified below, to following health care provider ("PROVIDER”):

Name of Facility: ___________________________
Phone: ___________________________
Address of Facility: ___________________________ City: ___________ State: ______ Zip: ___________

Type of Healthcare Provider: Check only one:
☐ Addiction Specialist ☐ Psychiatrist ☐ Therapist/Counselor ☐ Primary Care Physician ☐ Dentist
☐ Other ___________________________

I understand that by signing this authorization, TPAPN and PROVIDER may communicate with each other and exchange information (including information obtained from third-parties) relating to my participation in TPAPN and any assessment or treatment I am receiving, have received or will receive including, but not limited to:
• My status in TPAPN including my nonadherence, withdrawal or dismissal;
• Any problems I may be experiencing with substance use disorder and/or psychiatric disorder;
• Any assessment, diagnostic, treatment, rehabilitation or aftercare services I am receiving or have received; and
• My work performance and ability to practice nursing.

I authorize TPAPN and PROVIDER to disclose my PHI electronically.

I understand that my record may include information about my diagnosis and treatment for substance use disorder and/or psychiatric disorder, and other sensitive information that is protected by federal and/or state law.

I understand that federal law generally prohibits re-disclosure of substance abuse treatment without my consent.

RE-DISCLOSURE OF INFORMATION:

I understand that there is a potential for information disclosed pursuant to this authorization to a non-health care entity to be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations.

I release TPAPN from any liability for such re-disclosure(s).
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN TPAPN AND HEALTHCARE PROVIDER

PURPOSE OF DISCLOSURE:

TPAPN will use and disclose my PHI with PROVIDER in order to facilitate:

- Participation in the TPAPN program,
- Recovery from any problems I may be experiencing with substance use disorder and/or psychiatric disorder, and
- Return to nursing practice in a manner that is conducive to both my recovery and safe patient care.

REVOCATION:

I understand that I can revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it.

I understand TPAPN is relying on this Authorization in permitting me to participate in TPAPN program. In the event I withdraw or am dismissed from the program, TPAPN may notify PROVIDER that I have withdrawn or been dismissed from the program even if I revoke this Authorization and that PROVIDER likewise may share information about my assessment or treatment or notify TPAPN if I leave treatment even if I revoke this Authorization. I specifically authorize such disclosures even after my revocation of this Authorization.

I understand that I may revoke this Authorization only in a signed, written revocation provided TPAPN via certified U.S. mail addressed to TPAPN c/o Texas Nurses Foundation, 8501 N. MoPac Expwy., Ste. 400, Austin, TX 78759 or facsimile addressed to TPAPN at 512-467-2620 or such other address or facsimile TPAPN instructs me to use. The written revocation must include the following information:

- My name and address, TPAPN case number, and Texas nursing license number;
- PROVIDER’s name and address as set out above;
- Date I signed this Authorization as set out below; and
- My intent to revoke this authorization.

Unless a later date is specified in the revocation, the revocation will be effective at the close of the next business day following receipt by TPAPN.

If not previously revoked, this authorization will terminate 60 days after I complete, withdraw or am dismissed from TPAPN.

ACKNOWLEDGEMENT

I have read this authorization and understand what information will be used or disclosed or re-disclosed, who may use, and re-disclose the information, the recipient(s) of that information, and the circumstances in which my PHI will be disclosed/re-disclosed even after my written revocation.

Participant’s Printed Name: ________________________________

Participant’s Signature: ________________________________

Date: ________________________________  Case Number: ________________________________

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS: Substance use disorder information disclosed by TPAPN pursuant to this Authorization is required by federal law to include the following notice:

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
READ BEFORE SIGNING THE PARTICIPATION AGREEMENT

Abstinence Statement

TPAPN supports the foundation of a 12-Step based recovery plan that supports total abstinence for nurses that are participating in the substance use disorder and mental health programs. In accordance, participants must abstain completely from the use of all abusable substances. Use of the following are prohibited during participation:

- poppy seeds and hemp seeds/oil products
- products containing ethyl alcohol, i.e. vanilla extract, cooking wine, Nyquil, and hand sanitizers
- all alcoholic beverages including Near Beer or similar products
- unauthorized controlled medications or other abusable or potentially abusable medications
- illicit drugs/street drugs

Use of these substances may result in a positive drug test, case closure and referral to the Board of Nursing.

Prescribed Abusable Medications

Upon receipt of any prescription for controlled or abusable medications, do the following:

1. Refrain from nursing practice until approved to return to work.
2. Notify your Case Manager and Employer about your use of the prescribed medication(s) and to request time off of work.
3. Immediately submit a TPAPN Prescription Information/Treatment Progress Report form completed by your prescribing physician.
4. For approval to work, verify with your Case Manager that your TPAPN Prescription Information/Treatment Progress Report form and a negative drug test result have been received.

Participants requiring repeated or long-term use of controlled or abusable medications may not be appropriate for participation in TPAPN. The following categories of prescription drugs which are potentially abusable: all opioid pain relievers (includes tramadol), barbiturates, sedative-hypnotics, benzodiazepines, tranquilizers. Note that certain ADHD medications may be allowed with supporting documentation from two psychiatrists. Medications not allowed while in TPAPN are methadone and stimulant weight control medications (e.g., phentermine). Refer to the Talbott Medication Guide for a Safe Recovery included in your enrollment packet for a more detailed list of medications.

Suboxone/Subutex Information

Participants are not released to work in nursing while taking Suboxone or Subutex (buprenorphine/naloxone). Before attempting to discontinue these medications, Participants must effect a safe titration schedule with their medical doctor. In addition to a negative drug test result, TPAPN requires a period of 6-8 weeks after the last dose of these medications before approving a release to return to nursing practice. (Prescribing physician must document date medication was discontinued.)

Recovery Plan ‘House-Cleaning’

TPAPN recommends a thorough ‘house-cleaning’ as part of a comprehensive recovery plan to identify and locate all abusable substances in your home. First, find a safe person to assist you with this task such as your 12-Step sponsor. Next, go through all medicine cabinets, drawers, refrigerators, liquor cabinets, etc., to locate any medicine bottles that contain abusable medications, alcohol and any product that contains anything abusable or potentially abusable. Finally, arrange for the safe disposal of all of these items.

Refer to the Participant Handbook Chapter II, Section 8 ‘Abusable Medications’ for related program requirements
TPAPN PARTICIPATION AGREEMENT

I, ________________________________ the undersigned nurse, have voluntarily chosen to participate in the Texas Peer Assistance Program for Nurses (TPAPN), a board approved program operating under Chapter 467 of the Texas Health and Safety Code.

I understand that the terms of participation in TPAPN include the following and that these and the other terms of participation are explained in more detail in the “TPAPN Participant Handbook.” Any exceptions or modifications to the terms of participation are addressed on an individual basis and must be approved in writing by the TPAPN Program Director or Case Manager.

A. I acknowledge receipt of the “TPAPN Participant Handbook,” which sets out the terms of participation in TPAPN and I have had the opportunity to ask my TPAPN Case Manager questions.

B. I have read, understand and agree to adhere to the guidelines set forth within the “TPAPN Participant Handbook.”

C. I have read, understand and agree to adhere to the guidelines set forth within the “TPAPN Abstinence Statement.”

D. I agree to disclose my current employment status to TPAPN.

E. I agree to refrain from nursing practice as directed by TPAPN.

F. I agree to inform my employer(s) of any current licensing board action/discipline on my nursing license(s).

G. I have read and understand the TPAPN Participant’s Rights included in the “TPAPN Participant Handbook.”

H. I understand that TPAPN agrees to assist me only according to these terms, and I agree to abide by them.

1. Length of program: Five (5) years for advanced practice registered nurses or APRNs, i.e., nurse practitioners, nurse anesthetists, nurse-midwives and clinical nurse specialists; and three (3) years for other RNs and LVNs. If participating for psychiatric disorder only, program length is a minimum of one (1) year for all nurses and may be extended to accommodate the safe nursing practice requirement.

2. Participants are required to demonstrate safe nursing practice for a minimum of twelve (12) consecutive months if participating for SUD or dual diagnosis; six (6) months if participating for psychiatric disorder only. A nurse who does not return to nursing practice by the expected date of completion may be reported to the Texas Board of Nursing (BON).

3. Nurses who are unable to demonstrate the necessary, minimum length of participation of monitored good recovery and documented length of safe nursing practice shall have their participation in TPAPN extended, if eligible and willing to do so.

4. Participants requiring prescribed medications that are potentially abusable shall be required to refrain from nursing practice until TPAPN receives specified, negative drug tests and/or approves their return to practice.

5. Participants are responsible for timely payment of any fees required for participating in TPAPN. Failure to pay a required fee is grounds for dismissal from the program with referral to the Texas Board of Nursing (BON).

6. Participants must abstain completely from the use of all illicit substances, controlled medications (includes controlled prescription medications), or other abusable substances including alcohol. Participants are required to try non-narcotic approaches before controlled or potentially abusable medications are prescribed. Participants with conditions necessitating the use of controlled or potentially abusable prescription medications may not be appropriate for TPAPN.

7. Use of controlled prescriptions for acute medical conditions/surgeries may result in extending the length of participation.

8. Random and for cause drug screens are required for all participants experiencing problems with substance abuse/dependence and may be required for participants experiencing problems with mental illness. Participants are responsible for the cost of drug screens.

9. Any unauthorized use of abusable substances is considered inconsistent with good recovery and requires a complete re-evaluation of a nurses’ participation in TPAPN as well as an extension of the participation, a restart of the program or dismissal from TPAPN.

10. Participants with a positive drug screen must refrain from nursing practice pending review of the appropriateness of their continued participation in TPAPN. TPAPN considers a confirmed positive drug screen of any abusable substance as conclusive evidence of the use of that substance.

11. Participants may be dismissed from the program for nonadherence with any aspect of the participation agreement including a determination by TPAPN that a nurse has demonstrated behaviors inconsistent with good recovery.

12. Nurses who withdraw, or are dismissed from TPAPN are reported to the BON.

(CONTINUED ON NEXT PAGE)
TPAPN PARTICIPATION AGREEMENT

13. Participants must secure and complete appropriate treatment for their substance abuse/dependency and/or psychiatric disorder(s). Participants may be required to obtain assessment and treatment from TPAPN’s participating assessors and treatment providers. Participants are responsible for the cost of assessments and treatments.

14. Participants must have primary care physicians (PCPs) who are knowledgeable about their participation in TPAPN.

15. Participants are responsible for the cost of attending any required groups, e.g., facilitated support groups or recommended therapy.

16. Participants must have WORK RELEASE FORM(s) from their healthcare providers before accepting any employment in nursing.

17. A TPAPN Case Manager must approve participants’ return to work in nursing. It is a violation of your TPAPN agreement to return to work in nursing without this approval.

18. Participants must sign a TPAPN Work Agreement prior to returning to work in nursing.

19. Participants agree to adhere to TPAPN-imposed restrictions on their nursing practice, which may include but are not limited to: no access to controlled medications, no unsupervised practice and no overtime or on-call assignments. Additional restrictions apply for work as an APRN, and for distributive nursing practice.

20. Participants must sign consent forms authorizing TPAPN to exchange information with healthcare providers, treatment facilities, employers, potential employers, emergency contacts and the BON. Nurses not wishing to sign such consents are not eligible for TPAPN.

21. Participants are responsible for maintaining communication with their TPAPN case manager, advocate, and healthcare providers.

22. Participants are responsible for timely submission of all required forms to TPAPN.

23. If TPAPN ceases to operate for any reason, including lack of adequate funding, participants enrolled in the program will be referred to the BON unless the board directs TPAPN to refer the nurse to some alternative entity. What action, if any, is taken by the BON will be the sole decision of the BON.

24. No changes in the terms of participation or any TPAPN agreement or form may be made without consent from TPAPN.

25. Participants have the right to request disclosure of TPAPN Advocates’ association with treatment facilities.

26. Practicing in Other States Not Permitted without Prior Authorization; Nurse Compact License Status
   a) If a Third Party Referral Participant, Participant acknowledges and agrees that:
      1) TPAPN is a Texas-based program; participant must notify TPAPN immediately and obtain TPAPN’s prior authorization if she or he plans to practice in any state other than Texas; and
      2) Texas is a party state to the Nurse Licensure Compact, participant’s Texas licensure status will be changed from “Compact License” to “Single-State License” while in TPAPN, and he or she shall not practice in any other Compact Party State without the prior authorization of the Texas BON and TPAPN.
   b) If a Self-Referral Participant, Participant acknowledges and agrees that:
      1) TPAPN is a Texas-based program, he or she must notify TPAPN immediately and obtain TPAPN’s prior authorization if she or he plans to practice in any state other than Texas; and
      2) Texas is a party state to the Nurse Licensure Compact, he or she must not practice in another Compact Party State on his or her Compact License while in Texas without the prior authorization of the Texas BON and TPAPN.

Participant Name (Print): ____________________________ Nurse License #: __________________
Address: __________________________________________ City: __________________ State: _____ Zip: ________
Telephone: (H) ______________________ (W) __________________________ (Cell) __________________
Participant Name (Signature): ____________________________ Date: _______________________

SUBMIT PG. 1 & 2 TO TPAPN & RETAIN A COPY FOR PERSONAL RECORDS
TPAPN PARTICIPANT HISTORY

INSTRUCTIONS: to be completed by participant and submitted to TPAPN

1. Participant’s Name (PRINT) ________________________________ 2. Date __________________

3. Address ___________________________________________ City ________________ County ________________ State ______ Zip ______

4. Phone (Home) ______ (Work) ______ (Cell) ______ (Email) _____________________________

5. TX License ______ Exp: ___/_____ LVN____ RN____ APRN____ (Type) ______________ RX Auth: Yes ___ No ___

6. Do you presently hold a license to practice nursing or other licensed profession in other states? Yes ___ No ___
   (If yes, identify state, type, license no. and status) ______________________________________________________________________

7. SSN(Last 4 only) ___________ 8. Age ______ 9. Date of Birth _______________ 10. Sex: Female____ Male____

11. Status: Single___ Divorced___ Married___ Widowed___ Cohabiting___ Separated___ Other_________________________

12. Dependent children? Yes____ No____ (if yes, list names & ages) ______________________________________________________________________

13. Children live with: Both Parents ____ Mom ____ Dad ____ Joint Custody ____ Other_____________________

14. Medical History: List current medical conditions (diagnoses) ______________________________________________________________________

   Current medications (Rx and OTC) ______________________________________________________________________

   History of surgeries ______________________________________________________________________

   Current health insurance coverage? Yes____ No____ If yes, for what length of time? ______________________________________________________________________

15. Do you have any present/outstanding financial problems? Yes____ No____ If yes, specify: ______________________________________________________________________

16. Years of work experience as a nurse ______ 17. Name of Current Employer ______________________________

18. Most recent type of employment (hospital, clinic, home health, etc…) ________________________________

   List any current active military service, military reserve or National Guard assignments: ______________________________________________________________________

19. Current area of practice:
   _______________ Anesthesia __________________ Operating/Recovery Care __________________ Faculty __________________ Public Health
   _______________ Home Health ____________________ Telemetry ____________________ Neonatology __________________ Geriatrics
   _______________ Oncology ______________________ Emergency Care _______________ Psych/Mental Health/CD __________________ Occupational Health
   _______________ School Nurse ____________________ Medical/Surgical _______________ Utilization Review __________________ Rehabilitation
   _______________ Case Manager ____________________ Pediatrics ____________________ General Practice __________________ Other(s) (specify)
   _______________ Intensive/Critical Care ______________ Triage ______________________ Obstetrics/Gynecology __________________

20. Basic nursing education: check all that apply below
   ______ Vocational Nursing Program ______ Baccalaureate Degree in Nursing ______ Master of Science in Nursing
   ______ Associate Degree Nursing Program ______ Diploma Nursing Program ______ Other Degree(s) (specify) __________________

21. If you previously participated in TPAPN or other state alternative or licensing board program, specify program and when: ______________________________________________________________________

22. Has the licensing board of any state ever taken action against your nursing license(s) or are you currently being investigated by any state’s licensing board? Explain all that apply (specify all incidents, actions, and dates) (An Agreed Order is a board action) ______________________________________________________________________
TPAPN PARTICIPANT HISTORY

23. Do you have any current, PAST, or pending legal charges, convictions, deferred adjudications? If yes, list details including dates of arrests and/or incarcerations ____________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

FOR SUBSTANCE USE / DUAL DIAGNOSIS

24. Reason for referral: Alcohol____   Drugs____   Other____

25. Drug source: Workplace____   Legal (e.g., Alcohol)____  Prescription____  Street drugs____  Other____

26. Primary drug of use ________________________________ (list one preferred drug)

27. Check other drug(s) used: Alcohol____   Amphetamines____   Cocaine____   Marijuana____
Narcotic Analgesics: Codeine Based____   Darvon____   Demerol____   Dilauidid____   Heroin____   Morphine____   Opium____
   Percocet____   Percodan____   Fentanyl____   Methadone____   Talwin____   Tylox____   Vicodin____   Other (specify)________
Non-narcotic Analgesics: Nubain____   Stadol____   Soma____   Tramadol____   Other (specify)________________________
Hypnotics: Chloral Hydrate____   Halcion____   Phenobarbital____   Propofol (Diprivan)____   Other (specify)________________________
Anti-anxiety: Ativan____   Tranxene____   Xanax____   Librium____   Valium____   Klonopin____   Other (specify)________________________
Hallucinogens/Synthetics: LSD____   PCP____   GHB____   MDMA (Ecstasy)____   Mushrooms____   Mescaline____   Rohypnol____
   Inhalants____   Ketamine____   K2/Spice____   Bath Salts____   Kratom____   Other (specify)________________________

28. Currently obtaining treatment? Yes____   No____   (specify type, treatment provider, frequency, etc...)
________________________________________________________________________
________________________________________________________________________

29. Prior psychiatric or substance use treatment? Yes____   No____   (if yes, give details) ________________________________
________________________________________________________________________
________________________________________________________________________

30. Is there any history of substance use or psychiatric treatment in your family? Yes____   No____
(specify)________________________________________________________________________
________________________________________________________________________

FOR PSYCHIATRIC AND DUAL DIAGNOSIS

31. Psychiatric disorders: Anxiety_____   Bipolar_____   Depression_____   Schizophrenia_____   Schizoaffective_____  

32. Reason for referral to TPAPN ________________________________

33. Currently obtaining treatment? Yes____   No____   (specify type, treatment provider, frequency, etc...)

34. Prior psychiatric or substance use treatment? Yes____   No____   (if yes, give details)

35. Is there any history of substance use or psychiatric disorders in your family? Yes____   No____
(specify)________________________________________________________________________
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION TO LICENSING BOARDS
THIRD PARTY REFERRAL

NOTE: This authorization/consent form (“Authorization”) is to be used only by participants who are third party referrals. Self referrals must complete the self-referral form.

I understand a condition of my participation in the Texas Peer Assistance Program for Nurses (“TPAPN”) is that I authorize TPAPN to use and disclose my Protected Health Information (“PHI”) to the Texas Board of Nursing (“BON”) and any other state or federal agency that has issued me a license to provide patient care. I further understand that if I am issued licenses in addition to those I currently hold, that I will need to execute additional authorizations. Nurses who decline to sign this Authorization or such additional authorizations are not eligible to participate in TPAPN.

I, ___________________________ authorize ___________________________ to use and disclose my PHI for purposes other than treatment, payment, or health care operations. I specifically authorize TPAPN or TPAPN’s designated employee(s) to disclose my PHI, including my entire TPAPN record except for treatment records to the BON and the following recipient(s) (collectively “BON/BOARDS”):

Name:

(list any state or federal agency other than BON which has issued you a license to provide patient care)

I understand that by signing this authorization, TPAPN and BON/BOARDS may communicate with each other and exchange all information (including information obtained from third-parties except treatment records) relating to my participation in TPAPN, including, but not limited to:

- Any information provided to TPAPN by the third party at the time of referral or any information relating to my practice prior to my referral;
- The results of any assessment, evaluation or diagnosis performed or used for the purpose of determining my eligibility or continued eligibility for TPAPN;
- The dates of my participation in TPAPN;
- My status in the program including any violations of the terms of participation and the reason for my dismissal or withdrawal;
- Any professional judgments/conclusions (with supporting documentation) of health care providers that I am unable to practice nursing safely or that my practicing nursing would jeopardize patient care;
- The results of any drug tests;
- Any information that TPAPN, in its sole discretion, determines is evidence that I have exposed or am likely to expose patients or others unnecessarily to a risk of harm; and
- Prior participation in TPAPN.

I authorize TPAPN and BON/BOARDS to disclose my PHI electronically.

I understand that my record may include information about my diagnosis and treatment for substance use disorder and/or psychiatric disorder, and other sensitive information that is protected by federal and/or state law.

I understand that federal law generally prohibits re-disclosure of substance abuse treatment without my consent.

RE-DISCLOSURE OF INFORMATION:

I understand that there is a potential for information disclosed pursuant to this authorization to a non-health care entity to be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations.

I understand BON/BOARDS may re-disclose any information obtained under this Authorization to the same extent they disclose information relating to a complaint against a licensee.

I release TPAPN from any liability for such re-disclosure(s).

(Form continues on next page)
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION TO LICENSING BOARDS
THIRD PARTY REFERRAL

PURPOSE OF DISCLOSURE:
TPAPN will use and disclose my PHI with BON/BOARDS for the purpose of a) ensuring I do not engage in
nursing practice if I am unfit to practice or that may be inconsistent with safe patient care and b) determining if BON/BOARDS should take any
action against my nursing license or other license to provide patient care.

The disclosure of my entire record except for treatment records is necessary in order to accomplish these purposes.

REVOCATION:
I understand that I can revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on
it.

I understand TPAPN is relying on this Authorization in permitting me to participate in TPAPN program and may disclose the
information covered by this Authorization even after I revoke this Authorization. I further understand that TPAPN, even if I
revoke this Authorization, will report my final status in the program to BON/BOARDS including election not to participate,
withdrawal, failure to successfully complete, dismissal for nonadherence including failure to abide by restrictions imposed on my
practice, and if board-ordered to TPAPN, my successful completion. I specifically authorize such disclosures even after my
revocation of this Authorization.

I understand that I may revoke this Authorization only in a signed, written revocation provided TPAPN via certified U.S. mail
addressed to TPAPN c/o Texas Nurses Foundation, 8501 N. MoPac Expwy., Ste. 400, Austin, TX 78759 or facsimile addressed to TPAPN
at 512-467-2620 or such other address or facsimile TPAPN instructs me to use. The written revocation must include the following
information:
• My name and address, TPAPN case number, and Texas nursing license number;
• BON/BOARDS name and address as set out above;
• Date I signed this Authorization as set out below; and
• My intent to revoke this authorization.

Unless a later date is specified in the revocation, the revocation will be effective at the close of the next business day following
receipt by TPAPN.

If not previously revoked, this authorization will terminate the later of 60 days after I successfully complete TPAPN or 60 days after
final disposition by BON/BOARDS of any investigation of my practice including any appeals.

ACKNOWLEDGEMENT
I have read this authorization and understand what information will be used or disclosed or re-disclosed, who may use, and re-
disclose the information, the recipient(s) of that information, and the circumstances in which my PHI will be disclosed/re-disclosed
even after my written revocation.

Participant’s Printed Name: ____________________________

Participant’s Signature: ______________________________

Date: ____________________________ Case Number: __________

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS: Substance use disorder information disclosed by TPAPN pursuant to this
Authorization is required by federal law to include the following notice:
This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The
Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly
permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. general
authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules
restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION TO LICENSING BOARDS

SELF-REFERRAL

NOTE: This authorization/consent form (“Authorization”) is to be used only by participants who are self-referrals. Third-party referrals must complete the third-party referral authorization form.

I understand a condition of my participation in the Texas Peer Assistance Program for Nurses (“TPAPN”) is that I authorize TPAPN to use and disclose my Protected Health Information (“PHI”) to the Texas Board of Nursing (“BON”) and any other state or federal agency that has issued me a license to provide patient care. I further understand that if I am issued licenses in addition to those I currently hold, that I will need to execute additional authorizations. Nurses who decline to sign this Authorization or such additional authorizations are not eligible to participate in TPAPN.

I, ____________________________, authorize ____________________________ to use and disclose my PHI for purposes other than treatment, payment, or health care operations. I specifically authorize TPAPN or TPAPN’s designated employee(s) to disclose my PHI, including my entire TPAPN record except for treatment records to the BON and the following recipient(s) (collectively “BON/BOARDS”):

Name: ____________________________
(list any state or federal agency other than BON which has issued you a license to provide patient care)

I understand that by signing this authorization, TPAPN and BON/BOARDS may communicate with each other and exchange all information (including information obtained from third-parties except treatment records) relating to my participation in TPAPN, including, but not limited to:

• Any information provided to TPAPN by the third party at the time of referral or any information relating to my practice prior to my referral;
• The results of any assessment, evaluation or diagnosis performed or used for the purpose of determining my eligibility or continued eligibility for TPAPN;
• The dates of my participation in TPAPN;
• My status in the program including any violations of the terms of participation and the reason for my dismissal or withdrawal;
• Any professional judgments/conclusions (with supporting documentation) of health care providers that I am unable to practice nursing safely or that my practicing nursing would jeopardize patient care;
• The results of any drug tests;
• Any information that TPAPN, in its sole discretion, determines is evidence that I have exposed or am likely to expose patients or others unnecessarily to a risk of harm; and
• Prior participation in TPAPN.

I authorize TPAPN and BON/BOARDS to disclose my PHI electronically.

I understand that my record may include information about my diagnosis and treatment for substance use disorder and/or psychiatric disorder, and other sensitive information that is protected by federal and/or state law.

I understand that federal law generally prohibits re-disclosure of substance abuse treatment without my consent.

RE-DISCLOSURE OF INFORMATION:

I understand that there is a potential for information disclosed pursuant to this authorization to a non-health care entity to be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations.

I understand BON/BOARDS may re-disclose any information obtained under this Authorization to the same extent they disclose information relating to a complaint against a licensee.

I release TPAPN from any liability for such re-disclosure(s).

(Form continues on next page)
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION TO LICENSING BOARDS
SELF-REFERRAL

PURPOSE OF DISCLOSURE:

TPAPN will use and disclose my PHI with BON/BOARDS for the purpose of a) ensuring I do not engage in nursing practice if I am unfit to practice or that may be inconsistent with safe patient care and b) determining if BON/BOARDS should take any action against my nursing license or other license to provide patient care.

The disclosure of my entire record except for treatment records is necessary in order to accomplish these purposes.

REVOCATION:

I understand that I can revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it.

I understand TPAPN is relying on this Authorization in permitting me to participate in TPAPN program and may disclose the information covered by this Authorization even after I revoke this Authorization. In the event I do not successfully complete the program, I understand that TPAPN, even if I revoke this Authorization, will report my final status in the program to BON/BOARDS including withdrawal or dismissal for nonadherence including failure to abide by restrictions imposed on my practice. I specifically authorize such disclosures even after my revocation of this Authorization.

I understand that I may revoke this Authorization only in a signed, written revocation provided TPAPN via certified U.S. mail addressed to TPAPN c/o Texas Nurses Foundation, 8501 N. MoPac Expwy., Ste. 400, Austin, TX 78759 or facsimile addressed to TPAPN at 512-467-2620 or such other address or facsimile TPAPN instructs me to use. The written revocation must include the following information:

- My name and address, TPAPN case number, and Texas nursing license number;
- BON/BOARDS’s name and address as set out above;
- Date I signed this Authorization as set out below; and
- My intent to revoke this authorization.

Unless a later date is specified in the revocation, the revocation will be effective at the close of the next business day following receipt by TPAPN.

If not previously revoked, this authorization will terminate the later of 60 days after I successfully complete TPAPN or 60 days after final disposition by BON/BOARDS of any investigation of my practice including any appeals.

ACKNOWLEDGEMENT

I have read this authorization and understand what information will be used or disclosed or re-disclosed, who may use, and re-disclose the information, the recipient(s) of that information, and the circumstances in which my PHI will be disclosed/re-disclosed even after my written revocation.

Participant’s Printed Name: __________________________________________

Participant’s Signature: ______________________________________________

Date: ________________ Case Number: ______________________

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS: Substance use disorder information disclosed by TPAPN pursuant to this Authorization is required by federal law to include the following notice:

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN TPAPN AND HEALTHCARE PROVIDER

NOTE: This authorization/consent form ("Authorization") is to be used only for exchange of information between TPAPN and healthcare providers.

I understand a condition of my participation in the Texas Peer Assistance Program for Nurses ("TPAPN") is that I authorize TPAPN to use and disclose my Protected Health Information ("PHI") to my health care providers. I further understand that if I add or change providers, that I will need to execute additional authorizations. Nurses who decline to sign this Authorization or such additional authorizations are not eligible to participate in TPAPN.

I, ____________________________ (print name) authorize ____________________________ (name of participant) TPAPN to use and disclose my PHI for purposes other than treatment, payment, or health care operations. I specifically authorize TPAPN or TPAPN’s designated employee(s) to disclose my PHI, as identified below, to following health care provider ("PROVIDER"):  

Name of Facility:  
Phone:  
Address of Facility: City: State: Zip:  
Type of Healthcare Provider:  
☐ Addiction Specialist ☐ Psychiatrist ☐ Therapist/Counselor ☐ Primary Care Physician ☐ Dentist  
☐ Other  

I understand that by signing this authorization, TPAPN and PROVIDER may communicate with each other and exchange information (including information obtained from third-parties) relating to my participation in TPAPN and any assessment or treatment I am receiving, have received or will receive including, but not limited to:

- My status in TPAPN including my nonadherence, withdrawal or dismissal;
- Any problems I may be experiencing with substance use disorder and/or psychiatric disorder;
- Any assessment, diagnostic, treatment, rehabilitation or aftercare services I am receiving or have received; and
- My work performance and ability to practice nursing.

I authorize TPAPN and PROVIDER to disclose my PHI electronically.

I understand that my record may include information about my diagnosis and treatment for substance use disorder and/or psychiatric disorder, and other sensitive information that is protected by federal and/or state law.

I understand that federal law generally prohibits re-disclosure of substance abuse treatment without my consent.

RE-DISCLOSURE OF INFORMATION:

I understand that there is a potential for information disclosed pursuant to this authorization to a non-health care entity to be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations.

I release TPAPN from any liability for such re-disclosure(s).  

(Form continues on next page)
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN TPAPN AND HEALTHCARE PROVIDER

PURPOSE OF DISCLOSURE:

TPAPN will use and disclose my PHI with PROVIDER in order to facilitate:

- Participation in the TPAPN program,
- Recovery from any problems I may be experiencing with substance use disorder and/or psychiatric disorder, and
- Return to nursing practice in a manner that is conducive to both my recovery and safe patient care.

REVOCATION:

I understand that I can revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it.

I understand TPAPN is relying on this Authorization in permitting me to participate in TPAPN program. In the event I withdraw or am dismissed from the program, TPAPN may notify PROVIDER that I have withdrawn or been dismissed from the program even if I revoke this Authorization and that PROVIDER likewise may share information about my assessment or treatment or notify TPAPN if I leave treatment even if I revoke this Authorization. I specifically authorize such disclosures even after my revocation of this Authorization.

I understand that I may revoke this Authorization only in a signed, written revocation provided TPAPN via certified U.S. mail addressed to TPAPN c/o Texas Nurses Foundation, 8501 N. MoPac Expy., Ste. 400, Austin, TX 78759 or facsimile addressed to TPAPN at 512-467-2620 or such other address or facsimile TPAPN instructs me to use. The written revocation must include the following information:

- My name and address, TPAPN case number, and Texas nursing license number;
- PROVIDER’s name and address as set out above;
- Date I signed this Authorization as set out below; and
- My intent to revoke this authorization.

Unless a later date is specified in the revocation, the revocation will be effective at the close of the next business day following receipt by TPAPN.

If not previously revoked, this authorization will terminate 60 days after I complete, withdraw or am dismissed from TPAPN.

ACKNOWLEDGEMENT

I have read this authorization and understand what information will be used or disclosed or re-disclosed, who may use, and re-disclose the information, the recipient(s) of that information, and the circumstances in which my PHI will be disclosed/re-disclosed even after my written revocation.

Participant’s Printed Name: __________________________________________

Participant’s Signature: __________________________________________

Date: ___________________________ Case Number: ___________________________

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS: Substance use disorder information disclosed by TPAPN pursuant to this Authorization is required by federal law to include the following notice:

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN TPAPN AND HEALTHCARE PROVIDER

NOTE: This authorization/consent form (“Authorization”) is to be used only for exchange of information between TPAPN and healthcare providers.

I understand a condition of my participation in the Texas Peer Assistance Program for Nurses (“TPAPN”) is that I authorize TPAPN to use and disclose my Protected Health Information (“PHI”) to my health care providers. I further understand that if I add or change providers, that I will need to execute additional authorizations. Nurses who decline to sign this Authorization or such additional authorizations are not eligible to participate in TPAPN.

I, (print name) ___________________________________________________________ authorize (name of participant) ______________________________ to use and disclose my PHI for purposes other than treatment, payment, or health care operations. I specifically authorize TPAPN or TPAPN’s designated employee(s) to disclose my PHI, as identified below, to following health care provider (“PROVIDER”):

Name of Facility: ______________________________________________________

Phone: ______________________________

Address of Facility: __________________________ City: __________ State: ______ Zip: ______

Type of Healthcare Provider: Check only one:

☐ Addiction Specialist ☐ Psychiatrist ☐ Therapist/Counselor ☐ Primary Care Physician ☐ Dentist

☐ Other _________________________________________________________________________

I understand that by signing this authorization, TPAPN and PROVIDER may communicate with each other and exchange information (including information obtained from third-parties) relating to my participation in TPAPN and any assessment or treatment I am receiving, have received or will receive including, but not limited to:

• My status in TPAPN including my nonadherence, withdrawal or dismissal;
• Any problems I may be experiencing with substance use disorder and/or psychiatric disorder;
• Any assessment, diagnostic, treatment, rehabilitation or aftercare services I am receiving or have received; and
• My work performance and ability to practice nursing.

I authorize TPAPN and PROVIDER to disclose my PHI electronically.

I understand that my record may include information about my diagnosis and treatment for substance use disorder and/or psychiatric disorder, and other sensitive information that is protected by federal and/or state law.

I understand that federal law generally prohibits re-disclosure of substance abuse treatment without my consent.

RE-DISCLOSURE OF INFORMATION:

I understand that there is a potential for information disclosed pursuant to this authorization to a non-health care entity to be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations.

I release TPAPN from any liability for such re-disclosure(s).

(Form continues on next page)
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN TPAPN AND HEALTHCARE PROVIDER

PURPOSE OF DISCLOSURE:

TPAPN will use and disclose my PHI with PROVIDER in order to facilitate:
• Participation in the TPAPN program,
• Recovery from any problems I may be experiencing with substance use disorder and/or psychiatric disorder, and
• Return to nursing practice in a manner that is conducive to both my recovery and safe patient care.

REVOCATION:

I understand that I can revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it.

I understand TPAPN is relying on this Authorization in permitting me to participate in TPAPN program. In the event I withdraw or am dismissed from the program, TPAPN may notify PROVIDER that I have withdrawn or been dismissed from the program even if I revoke this Authorization and that PROVIDER likewise may share information about my assessment or treatment or notify TPAPN if I leave treatment even if I revoke this Authorization. I specifically authorize such disclosures even after my revocation of this Authorization.

I understand that I may revoke this Authorization only in a signed, written revocation provided TPAPN via certified U.S. mail addressed to TPAPN c/o Texas Nurses Foundation, 8501 N. MoPac Expwy., Ste. 400, Austin, TX 78759 or facsimile addressed to TPAPN at 512-467-2620 or such other address or facsimile TPAPN instructs me to use. The written revocation must include the following information:
• My name and address, TPAPN case number, and Texas nursing license number;
• PROVIDER’s name and address as set out above;
• Date I signed this Authorization as set out below; and
• My intent to revoke this authorization.

Unless a later date is specified in the revocation, the revocation will be effective at the close of the next business day following receipt by TPAPN.

If not previously revoked, this authorization will terminate 60 days after I complete, withdraw or am dismissed from TPAPN.

ACKNOWLEDGEMENT

I have read this authorization and understand what information will be used or disclosed or re-disclosed, who may use, and re-disclose the information, the recipient(s) of that information, and the circumstances in which my PHI will be disclosed/re-disclosed even after my written revocation.

Participant’s Printed Name: __________________________________________
Participant’s Signature: ____________________________________________
Date: ____________________________ Case Number: __________________________

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS: Substance use disorder information disclosed by TPAPN pursuant to this Authorization is required by federal law to include the following notice:

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN TPAPN AND EMPLOYER

NOTE: This authorization/consent form (“Authorization”) is to be used only for exchange of information between TPAPN and employers.

I understand a condition of my participation in the Texas Peer Assistance Program for Nurses (“TPAPN”) is that I authorize TPAPN to use and disclose my Protected Health Information (“PHI”) to my employer. I further understand that if I change employers, I will need to execute additional authorizations. Nurses who decline to sign this Authorization or such additional authorizations are not eligible to participate in TPAPN.

I, (print name) __________________________________________________________________________, authorize
(name of participant)
TPAPN to use and disclose my PHI for purposes other than treatment, payment, or health care operations. I specifically authorize TPAPN or TPAPN’s designated employee(s) to disclose my PHI, as identified below, to my employer (“EMPLOYER”):

Employing Facility Name: ____________________________________________________________________
(name of employing facility only)

Phone: __________________________________________________________________________

Address _____________________________________________________________________________
City: ___________________ State: ___________ Zip: ____________
(address of employing facility only)

I understand that by signing this authorization, TPAPN and EMPLOYER may communicate with each other and exchange information (including information obtained from third-parties) relating to my participation in TPAPN and my employment including, but not limited to, my:

- Status in TPAPN including nonadherence, withdrawal or dismissal;
- Status in treatment or rehabilitation, including my progress or lack of progress;
- Work performance;
- Assessment of my ability to practice nursing;
- Return to work accommodations; and
- The nature of my referral

I authorize TPAPN and EMPLOYER to disclose my PHI electronically.

I understand that my record may include information about my diagnosis and treatment for substance use disorder and/or psychiatric disorder, and other sensitive information that is protected by federal and/or state law.

I understand that federal law generally prohibits re-disclosure of substance abuse treatment without my consent.

RE-DISCLOSURE OF INFORMATION:

I understand that there is a potential for information disclosed pursuant to this authorization to a non-health care entity to be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations.

I further understand that by disclosing information to EMPLOYER, EMPLOYER may disclose that information to my immediate co-workers who have a legitimate need to know and authorize such re-disclosures.

I release TPAPN from any liability for such re-disclosure(s).

(Form continues on next page)
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN TPAPN AND EMPLOYER

PURPOSE OF DISCLOSURE:

TPAPN will use and disclose my PHI with EMPLOYER in order to facilitate:

- Participation in the TPAPN program;
- Recovery from any problems I may be experiencing with substance use disorder and/or psychiatric disorder; and
- Return to nursing practice in a manner that is conducive to both my recovery and safe patient care.

REVOCATION:

I understand that I can revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it.

I understand TPAPN is relying on this Authorization in permitting me to participate in TPAPN program. Therefore, in the event I withdraw or am dismissed from the program, TPAPN may notify EMPLOYER that I have withdrawn or been dismissed from the program even if I revoke this Authorization and that EMPLOYER likewise may notify TPAPN about my work performance or if I leave its employment even if I revoke this Authorization. I specifically authorize such disclosures even after my revocation of this Authorization.

I understand that I may revoke this Authorization only in a signed, written revocation provided TPAPN via certified U.S. mail addressed to TPAPN c/o Texas Nurses Foundation, 8501 N. MoPac Expwy., Ste. 400, Austin, TX 78759 or facsimile addressed to TPAPN at 512-467-2620 or such other address or facsimile TPAPN instructs me to use. The written revocation must include the following information:

- My name and address, TPAPN case number, and Texas nursing license number;
- EMPLOYER’s name and address as set out above;
- Date I signed this Authorization as set out below; and
- My intent to revoke this authorization.

Unless a later date is specified in the revocation, the revocation will be effective at the close of the next business day following receipt by TPAPN.

If not previously revoked, this authorization will terminate 60 days after I complete, withdraw or am dismissed from TPAPN.

ACKNOWLEDGEMENT

I have read this authorization and understand what information will be used or disclosed or re-disclosed, who may use, and re-disclose the information, the recipient(s) of that information, and the circumstances in which my PHI will be disclosed/re-disclosed even after my written revocation.

Participant’s Printed Name: ______________________________________

Participant’s Signature: ______________________________________

Date: ________________________  Case Number: ____________________

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS: Substance use disorder information disclosed by TPAPN pursuant to this Authorization is required to include the following notice:

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN TPAPN AND EMPLOYER

NOTE: This authorization/consent form (“Authorization”) is to be used only for exchange of information between TPAPN and employers.

I understand a condition of my participation in the Texas Peer Assistance Program for Nurses (“TPAPN”) is that I authorize TPAPN to use and disclose my Protected Health Information (“PHI”) to my employer. I further understand that if I change employers, I will need to execute additional authorizations. Nurses who decline to sign this Authorization or such additional authorizations are not eligible to participate in TPAPN.

I, ________________________________________________________________ (name of participant)

authorize

TPAPN to use and disclose my PHI for purposes other than treatment, payment, or health care operations. I specifically authorize TPAPN or TPAPN’s designated employee(s) to disclose my PHI, as identified below, to my employer (“EMPLOYER”):

Employing Facility Name: ________________________________ Phone: ____________________

(name of employing facility only)

Address_________________________City:______________State:__________Zip:________

(address of employing facility only)

I understand that by signing this authorization, TPAPN and EMPLOYER may communicate with each other and exchange information (including information obtained from third-parties) relating to my participation in TPAPN and my employment including, but not limited to, my:

• Status in TPAPN including noncompliance, withdrawal or dismissal;
• Status in treatment or rehabilitation, including my progress or lack of progress;
• Work performance;
• Assessment of my ability to practice nursing;
• Return to work accommodations; and
• The nature of my referral

I authorize TPAPN and EMPLOYER to disclose my PHI electronically.

I understand that my record may include information about my diagnosis and treatment for substance use disorder and/or psychiatric disorder, and other sensitive information that is protected by federal and/or state law.

I understand that federal law generally prohibits re-disclosure of substance abuse treatment without my consent.

RE-DISCLOSURE OF INFORMATION:

I understand that there is a potential for information disclosed pursuant to this authorization to a non-health care entity to be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations.

I further understand that by disclosing information to EMPLOYER, EMPLOYER may disclose that information to my immediate co-workers who have a legitimate need to know and authorize such re-disclosures.

I release TPAPN from any liability for such re-disclosure(s).

(Form continues on next page)
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN TPAPN AND EMPLOYER

PURPOSE OF DISCLOSURE:

TPAPN will use and disclose my PHI with EMPLOYER in order to facilitate:

- Participation in the TPAPN program;
- Recovery from any problems I may be experiencing with substance use disorder and/or psychiatric disorder; and
- Return to nursing practice in a manner that is conducive to both my recovery and safe patient care.

REVOCATION:

I understand that I can revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it.

I understand TPAPN is relying on this Authorization in permitting me to participate in TPAPN program. Therefore, in the event I withdraw or am dismissed from the program, TPAPN may notify EMPLOYER that I have withdrawn or been dismissed from the program even if I revoke this Authorization and that EMPLOYER likewise may notify TPAPN about my work performance or if I leave its employment even if I revoke this Authorization. I specifically authorize such disclosures even after my revocation of this Authorization.

I understand that I may revoke this Authorization only in a signed, written revocation provided TPAPN via certified U.S. mail addressed to TPAPN c/o Texas Nurses Foundation, 8501 N. MoPac Expwy., Ste. 400, Austin, TX 78759 or facsimile addressed to TPAPN at 512-467-2620 or such other address or facsimile TPAPN instructs me to use. The written revocation must include the following information:

- My name and address, TPAPN case number, and Texas nursing license number;
- EMPLOYER’s name and address as set out above;
- Date I signed this Authorization as set out below; and
- My intent to revoke this authorization.

Unless a later date is specified in the revocation, the revocation will be effective at the close of the next business day following receipt by TPAPN.

If not previously revoked, this authorization will terminate 60 days after I complete, withdraw or am dismissed from TPAPN.

ACKNOWLEDGEMENT

I have read this authorization and understand what information will be used or disclosed or re-disclosed, who may use, and re-disclose the information, the recipient(s) of that information, and the circumstances in which my PHI will be disclosed/re-disclosed even after my written revocation.

Participant’s Printed Name: ____________________________

Participant’s Signature: ____________________________

Date: ____________________________ Case Number: ____________________________

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS: Substance use disorder information disclosed by TPAPN pursuant to this Authorization is required to include the following notice:

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION TO 
FAMILY MEMBERS / SIGNIFICANT OTHERS / EMERGENCY CONTACT

I understand a condition of my participation in the Texas Peer Assistance Program for Nurses (“TPAPN”) is that I authorize TPAPN to use and disclose my Protected Health Information (“PHI”) to an emergency contact. I further understand that if I wish to add a contact, I will need to execute additional authorizations. Nurses who decline to sign this Authorization or such additional authorizations are not eligible to participate in TPAPN.

I, (print name) ___________________________ authorize ___________________________ to use and disclose my PHI for purposes other than treatment, payment, or health care operations. I specifically authorize TPAPN or TPAPN’s designated employee(s) to disclose my PHI, including my entire TPAPN record, to my emergency contact(s) listed below (CONTACT(S):

Name: ___________________________ Relationship: ___________________________
(name of emergency contact)
Address_________________________ City: ___________ State: ___________ Zip: ___________
Phone: (Home) ___________ (Work) ___________ (Cell) ___________ (Best # To Call): ___________

I understand that by signing this authorization, TPAPN and CONTACT(S) may communicate with each other and exchange all information (including information obtained from third-parties) relating to my participation in TPAPN and any problems I am experiencing with substance use disorder and/or psychiatric disorders.

I authorize to TPAPN and CONTACT(S) to disclose my PHI electronically.

I understand that my record may include information about my diagnosis and treatment for substance use disorder and/or psychiatric disorder, and other sensitive information that is protected by federal and/or state law.

I understand that federal law generally prohibits re-disclosure of substance abuse treatment without my consent.

RE-DISCLOSURE OF INFORMATION:

I understand that there is a potential for information disclosed pursuant to this authorization to a non-health care entity to be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations.

I further understand that by disclosing information to CONTACT(S), CONTACT(S) may disclose my information to healthcare providers, emergency personnel and law enforcement.

I release TPAPN from any liability for such re-disclosure(s).

PURPOSE OF DISCLOSURE:

TPAPN will use and disclose my PHI with CONTACT(S) in order to facilitate a timely and appropriate response in the event of an emergency such as a medical emergency or there is concern I have exposed myself or others, or am likely to expose myself or others, to a risk of harm.

The disclosure of my entire record is necessary in order to accomplish these purposes.

(Form continues on next page)
TPAPN AUTHORIZATION TO DISCLOSE INFORMATION TO
FAMILY MEMBERS / SIGNIFICANT OTHERS / EMERGENCY CONTACT

REVOCATION:

I understand that I can revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it.

I understand TPAPN is relying on this Authorization in permitting me to participate in TPAPN program and may disclose the information covered by this Authorization even if I revoke this Authorization. In the event of an emergency, TPAPN may notify CONTACT(S) of that emergency, my participation, and any problems I am experiencing with substance use disorder and/or psychiatric disorders in TPAPN even if I revoke this Authorization and that CONTACT(S) likewise may notify TPAPN in the event of an emergency even if I revoke this Authorization. I specifically authorize such disclosures even after my revocation of this Authorization.

I understand that I may revoke this Authorization only in a signed, written revocation provided TPAPN via certified U.S. mail addressed to TPAPN c/o Texas Nurses Foundation, 8501 N. MoPac Expwy., Ste. 400, Austin, TX 78759 or facsimile addressed to TPAPN at 512-467-2620 or such other address or facsimile TPAPN instructs me to use. The written revocation must include the following information:

- My name and address, TPAPN case number, and Texas nursing license number;
- CONTACT(S) name and address as set out above;
- Date I signed this Authorization as set out below; and
- My intent to revoke this authorization.

Unless a later date is specified in the revocation, the revocation will be effective at the close of the next business day following receipt by TPAPN.

If not previously revoked, this authorization will terminate 60 days after I complete, withdraw or am dismissed from TPAPN.

ACKNOWLEDGEMENT

I have read this authorization and understand what information will be used or disclosed or re-disclosed, who may use, and re-disclose the information, the recipient(s) of that information, and the circumstances in which my PHI will be disclosed/re-disclosed even after my written revocation.

Participant’s Printed Name: _______________________________________________

Participant’s Signature: ______________________________________________

Date: ____________________________  Case Number: _________________________

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS: Substance use disorder information disclosed by TPAPN pursuant to this Authorization is required by federal law to include the following notice:

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
GENERAL AUTHORIZATION TO RELEASE INFORMATION

Under federal law an authorization for Texas Peer Assistance Program for Nurses/Extended Evaluation Program/Mental Health Support Program collectively known as TPAPN/EEP/MHSP, hereafter referred to as “TPAPN” to release information to an individual or entity at the request of the participant must meet certain requirements. A general consent for release of medical information is not sufficient. To avoid delay, TPAPN strongly recommends this form be used.

I, (print name) ________________________________ authorize ________________________________ (name of participant) TPAPN to use and disclose my PHI for purposes other than treatment, payment, or health care operations. I specifically authorize TPAPN or TPAPN’s designated employee(s) to disclose my PHI, as identified below, to “RECIPIENT”:

Name: ____________________________________________ Phone: ______________________

(name of specific person or organization to which disclosure is to be made)

Address __________________________________________ City: __________ State: ______ Zip: _______

I understand that by signing this authorization, TPAPN and RECIPIENT may communicate with each other and exchange information (including information obtained from third-parties) relating to my participation in TPAPN including, but not limited to:

(Check the information to be disclosed)

☐ Drug Screens ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS)
☐ Meeting Attendance (12 Step Meetings) ☐ Mental/Behavioral Health and Developmental Disability Treatment
☐ Treatment Recommendations ☐ Support Group
☐ Drug Abuse Treatment ☐ Work Agreement
☐ Alcohol Treatment ☐ Other
☐ Hepatitis B or C Testing

If Other (please specify) ________________________________________________

☐ Entire Record not including treatment records. Must state why entire record is needed to be disclosed: ________________________________

I authorize TPAPN and RECIPIENT to disclose my PHI electronically.

I understand that my record may include information about my diagnosis and treatment for substance use disorder and/or psychiatric disorder, and other sensitive information that is protected by federal and/or state law.

I understand that federal law generally prohibits re-disclosure of substance abuse treatment without my consent.

RE-DISCLOSURE OF INFORMATION:

I understand that there is a potential for information disclosed pursuant to this authorization to a non-health care entity to be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations.

I release TPAPN/EEP/MHSP from any liability for such re-disclosure(s).

PURPOSE OF DISCLOSURE:

TPAPN will use and disclose my PHI with RECIPIENT for the following purpose:

☐ Probation ☐ Attorney
☐ Other Peer Assistance Alternative Program ☐ Other

If Other (please specify) ________________________________________________
GENERAL AUTHORIZATION TO RELEASE INFORMATION

REVOCATION:

I understand that I can revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it.

I understand that I may revoke this Authorization only in a signed, written revocation provided TPAPN via certified U.S. mail addressed to TPAPN c/o Texas Nurses Foundation, 8501 N. MoPac Expy., Ste. 400, Austin, TX 78759 or facsimile addressed to TPAPN at 512-467-2620 or such other address or facsimile TPAPN instructs me to use. The written revocation must include the following information:

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ACKNOWLEDGEMENT

I have read this authorization and understand what information will be used or disclosed or re-disclosed, who may use, and re-disclose the information, the recipient(s) of that information, and the circumstances in which my PHI will be disclosed/re-disclosed even after my written revocation.

Participant’s Printed Name: ______________________________________________________________

Participant’s Signature: _______________________________________________________________

Date: ____________________________ Case Number: ______________________________

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS: Substance use disorder information disclosed by TPAPN pursuant to this Authorization is required by federal law to include the following notice:

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PRESCRIPTION/PROGRESS REPORT

INSTRUCTIONS: This form is to be completed for all prescription medications and/or all healthcare provider visits. This form MUST be completed by the healthcare provider only and then submitted to TPAPN by participant.

<table>
<thead>
<tr>
<th>DATE</th>
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HEALTHCARE PROVIDER INFORMATION: (Please Print)

Name: __________________________________________________________ Credentials: ______________________________
Facility/Name of Practice: ___________________________________________________________________________________
Address: _________________________________________________________ City/State/Zip: _______________________________
Phone: ____________________________________________________   Fax: ______________________________________________

HEALTHCARE PROVIDER’S REPORT:

Appointment frequency ____________________________________________ Date of next appointment: ______________
Diagnosis(es)/Disorder(s) treated: __________________________________________________________________________

Y___  N___ Does nurse demonstrate insight, awareness and judgment necessary to manage illness?
Y___  N___ Medication compliance
Y___  N___ Keeping appointments
Y___  N___ Agrees to refrain from nursing practice and contact provider if unable to practice safely.
Y___  N___ Based on the above information and provider’s clinical judgment, is nurse safe to practice at this time?
(If no, explain below)
____________________________________________________________________________________________________________

Treatment Progress Report: (If more space is needed, please attach another sheet)

Healthcare Provider Signature _____________________________ Date ______________
### PRESCRIPTION/PROGRESS REPORT

**INSTRUCTIONS:** This form is to be completed for all prescription medications and/or all healthcare provider visits. **This form MUST be completed by the healthcare provider only** and then submitted to TPAPN by participant.

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Y___ N___ Does nurse demonstrate insight, awareness and judgment necessary to manage illness?

Y___ N___ Medication compliance

Y___ N___ Keeping appointments

Y___ N___ Agrees to refrain from nursing practice and contact provider if unable to practice safely.

Y___ N___ Based on the above information and provider’s clinical judgment, is nurse safe to practice at this time?

(If no, explain below)

__________________________________________________________

---

**Treatment Progress Report:** (If more space is needed, please attach another sheet)

---

**Healthcare Provider Signature** ____________________________ **Date** ____________

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*C/o Texas Nurses Foundation, 8501 N. MoPac Expwy., Ste. 400 • Austin, TX • 78759 • 1-800-288-5528 • FAX 512/467-2620 • www.tpapn.org*
TPAPN PARTICIPANT SELF REPORT

INSTRUCTIONS: Submit monthly report electronically through your drug testing administrator account.

If this is a change of address you are required to immediately enter the new contact information through your drug testing administrator account.

Name (PRINT): _____________________________________________________________________________

(Address) __________________________________________________________________________________

(City)______________________________________________________ (State) ________ (Zip) _____________

Phone Numbers:  (HM) ________________ (WK)___________________ (CELL) ___________________

Email for contact by TPAPN: ___________________________________________________________________

ARE YOU CURRENTLY EMPLOYED? ☐ NURSING  ☐ NON-NURSING  ☐ NOT EMPLOYED

PLACE OF EMPLOYMENT: ______________________________________ Addr: __________________________________________

FOR ALL PARTICIPANTS

1. List all current prescription and over the counter medications:

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</table>

2. During my participation I agree to use one pharmacy only for all prescription medications as follows:

Name: _____________________ Address:_______________________________________________ Phone:_________________

3. Did your physician(s) send TPAPN the updated TPAPN Prescription Information form for the above prescriptions?

YES____ NO____ NO Changes ____ If not sent, I will send this on: (date) _______________________ ____________________

4. During my participation I agree to use the following dentist only:

Name: _____________________ Address:_______________________________________________ Phone:_________________

5. How is participating in TPAPN benefiting you? ___________________________________________________________________

_______________________________________________ If TPAPN is not benefiting you, what would help?  

______________________________________________________________ __________________________________________

6. What major changes have occurred in your life this month? ___________________ ____________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

7. What are you doing to take care of yourself? ___________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________
TPAPN PARTICIPANT SELF REPORT

8. Who is your TPAPN advocate? __________________________________________ Advocate’s phone # ___________________
   How many times have you seen your advocate this month? ______________________
   How many times have you spoken to your advocate by phone this month? __________

FOR SUBSTANCE ABUSE/DEPENDENCY

1. How many AA/NA meetings per week are you attending? ____________ What step are you working? __________________
   What does this step mean to you? __________________________________________________________________________
   ________________________________________________________________________________________________________
   ________________________________________________________________________________________________________

2. Your 12 step sponsor’s first name? ____________________________ How often do you contact your sponsor? __________
   When is the last time you met with your sponsor? _____________________________________________________________

3. Are you still attending aftercare? YES____ NO____ If yes, has your treatment provider sent a progress report? YES____ NO____

4. Briefly describe your current treatment/relapse prevention plan: ____________________________________________________
   __________________________________________________________________________________________________________
   __________________________________________________________________________________________________________

5. Name of your psychiatrist: _________________________________________ Dates seen this month: ________________

6. Name of your therapist: ___________________________________________ Dates seen this month: ________________

Signature ______________________________________ Date _____________

FOR PSYCHIATRIC AND DUAL DIAGNOSIS

NOTE: WRITE N/A IF NOT APPLICABLE OR IF ALREADY ANSWERED IN PREVIOUS SECTION

1. Date discharged from inpatient, day hospital, or intensive outpatient program: ______________________________________
   Name/location of this facility: _____________________________________________________________________________

2. Name of your psychiatrist: _________________________________________ Date(s) seen this month: ________________

3. Has your psychiatrist sent a treatment progress report and prescription update to TPAPN since your last appointment using the
   PRESCRIPTION INFORMATION form? _____________ If not, date psychiatrist’s report will be submitted: ______________ and
   every three-four months thereafter.

4. Describe your current psychiatric treatment plan: ______________________________________________________________
   _______________________________________________________________________________________________________

5. Name of your therapist: ______________________________________ Date(s) seen this month: ________________

6. Has therapist sent a treatment update to TPAPN since your last appointment? ______________ If not, therapist’s report will be
   submitted: ______________ and every three-four months thereafter.

Signature ______________________________________ Date _____________

If any additional comments or information, please use another sheet.
TPAPN PARTICIPANT SELF REPORT

MONTH/YEAR: _________________________

INSTRUCTIONS: Submit monthly report electronically through your drug testing administrator account.

If this is a change of address you are required to immediately enter the new contact information through your drug testing administrator account.

Name (PRINT): ____________________________________________________________

(Address) __________________________________________________________________

(City) __________________________ (State) _______ (Zip) __________

Phone Numbers: (HM) _______________ (WK) ___________________ (CELL) __________

Email for contact by TPAPN: __________________________________________________

ARE YOU CURRENTLY EMPLOYED? ☐ NURSING ☐ NON-NURSING ☐ NOT EMPLOYED

PLACE OF EMPLOYMENT: ___________________________ Addr: __________________

FOR ALL PARTICIPANTS

1. List all current prescription and over the counter medications:

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4. During my participation I agree to use the following dentist only:

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   If TPAPN is not benefiting you, what would help? __________________________

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   _____________________________________________________________
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TPAPN PARTICIPANT SELF REPORT

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   How many times have you seen your advocate this month? __________________
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FOR SUBSTANCE ABUSE/DEPENDENCY

1. How many AA/NA meetings per week are you attending? __________ What step are you working? ________________
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Signature __________________________ Date ______________

FOR PSYCHIATRIC AND DUAL DIAGNOSIS

NOTE: WRITE N/A IF NOT APPLICABLE OR IF ALREADY ANSWERED IN PREVIOUS SECTION

1. Date discharged from inpatient, day hospital, or intensive outpatient program: ________________________________
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4. Describe your current psychiatric treatment plan: __________________________________________________

5. Name of your therapist: ________________________________ Date(s) seen this month: ____________________

6. Has therapist sent a treatment update to TPAPN since your last appointment? __________ If not, therapist’s report will be
   submitted: ____________________ and every three-four months thereafter.

Signature __________________________ Date ______________

If any additional comments or information, please use another sheet.
TPAPN MEETING ATTENDANCE RECORD

90/90 start date (if applicable) ______________________ Month/Year____________

Case Manager __________________________

Instructions: You must complete the paper meeting attendance form, have it signed at each meeting and retain the forms throughout your participation as your Case Manager may request proof of attendance at any time. Also complete and submit electronic Meeting Attendance Record monthly.

Note: Meeting documents are reviewed for accuracy of dates and validity of signatures. Falsification of this document will be considered nonadherence with the Participation Agreement and could result in dismissal. Please use this form to track AA, NA, therapy, aftercare, psychiatric visits, etc. by entering the appropriate information.

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<th>NAME: Name of 12 step group; aftercare; psychiatrist; therapist /counselor; or other</th>
<th>TYPE: NA or AA; Med check; therapy; aftercare, etc.</th>
<th>SIGNATURE: 12 step chairperson; psychiatrist; therapist/counselor; or group facilitator signature</th>
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Participant (Print) __________________________ (Signature) __________________________ Date __________

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Participant (Print) __________________________ (Signature) __________________________ Date __________

C/o Texas Nurses Foundation, 8501 N. MoPac Expy., Ste. 400 • Austin, TX • 78759 • 1-800-288-5528 • FAX 512/467-2620 • www.tpapn.org
Work Release Form

Nurse Participant Name: ____________________________________________ RN/LVN/APRN/CRNA
(Print or type client’s/patient’s name)      (circle one)

TPAPN Case Manager: ______________________________________________

The above nurse has been under my/our care since _______/_______/________
(month)       (day)            (year)

He/she is considered safe to work in nursing as of _____/_____/_____,   provided the nurse is compliant with TPAPN’s work guidelines.
(month)    (day)     (year)

Client’s anticipated actual/date of discharge is   _______/_______/_______
(month)             (day)            (year)

If client is being discharged from treatment at the time of this work release, please attach a separate discharge summary with admit/discharge dates, diagnoses, and continuing care recommendations.

If not currently being discharged from treatment, please describe client’s treatment plan: _________________________
__________________________________________________________________________________________________

Healthcare Provider’s conditions for work release, if any: _____________________________________________________________
____________________________________________________________________ ________________________________________
________________________________________________________________________________ ____________________________

Is there any reason the nurse should not work nights?   Yes____    No____     (if yes, explain)_________________________________
______________________________________________________________________ ______________________________________
____________________________________________________________________ ________________________________________

Name & Credentials of Healthcare Provider:  _______________________________________________________________________
(PLEASE PRINT)

Name of Treatment Program/Hospital: ____________________________________________________________________________

Address: __________________________________________________ City: ___________________State:______ Zip:_____________

Phone:__________________________ Fax: ________________________Email: ___________________________________________

_______________________________________________________________________Date:________________________________
(Signature of Provider completing this form)
Prior to returning to work in nursing, you **MUST** have case manager approval.

It is a violation of your TPAPN agreement to return to work without this approval.
Job Interview Tips for TPAPN Participants - the ABC's

Appearance:
☐ Dress appropriately: business-attire
☐ Pay attention to your hair, shoes, and fingernails
☐ Smile - with sincerity

Attitude:
Be: ☐ Professional ☐ Friendly ☐ Confident ☐ Factual ☐ Focused ☐ Honest
Be: ☐ POSITIVE. Recruiters want to see enthusiasm for the position. Visualize yourself being successful in your interview.
Be: ☐ Willing to work anywhere that’s appropriate under TPAPN. Get your foot in the door. It may not be your dream job, but it is a place to start.

Be Prepared:
☐ Be on time.
☐ Turn off cell phones or pagers.
☐ Bring copies of licensure certificates and references.
☐ Prepare for behavioral-based questions. Example: “Tell me about a time when you worked with a difficult physician and how you handled it”. Be specific in response.
☐ If you lack a skill or experience in an area, let the recruiter know. They may be willing to train or they may have another job opening that is a better fit.
☐ Take time to learn about the position, their organization, mission, etc., and write down questions to ask the interviewer.

Body Language:
☐ Look your interviewer in the eye; sit up straight; refrain from crossing your arms. Remember & use their names. Smile.

Consider:
When is the right time to disclose your participation in TPAPN?
☐ During the application paperwork process, if asked: “Do you have restrictions on your license or have you been convicted of a felony?” Respond “I will discuss this upon interview.”
☐ During the interview process, disclose your participation in TPAPN using these tips (as applicable to your participation) that are benefits to the employer.
   ☐ I am being drug tested at no cost to your facility. I check-in daily to see if I am being selected.
   ☐ I am available to work for your facility for a minimum of one year or longer if you agree.
   ☐ I have a TPAPN Case Manager who will be in direct communication with you.
   ☐ I have a TPAPN volunteer nurse advocate for support who may also be available to provide education to your facility and to communicate directly with you.

Closing:
Be proactive in selling yourself/your restrictions: “While another nurse is giving my meds, I'll assume other duties for this nurse. We'll make a plan in the Work Agreement meeting with my advocate.” Refer to the article in the TX BON Bulletin, April 2010, “Creative Staffing Solutions”: “Teamwork and collaboration are strategies in a systems approach to improving the safety and quality of nursing services. The best practice suggestion focused on the buddy system, which enabled nurses to help each other during critical times of the day.”
Send a thank you note via email within 48 hours of the interview to every person with whom you interviewed expressing appreciation for the opportunity – show them that you are serious and that you have both style and substance.
WORK Agreement - IMPORTANT POINTS

- TPAPN work restrictions: (See work agreement, Section 4, for details)
  - The first six months of employment:
    - Narcotic/controlled substance restriction
    - On-call restriction
  - Throughout the entire time the nurse is in TPAPN:
    - No autonomous or unsupervised position
    - No shift longer than 12 hours
    - No multiple employers
    - No self-employed practice
    - No short-term staffing or work as a traveler
    - No floating
    - No more than 96 hours work per two week pay period
    - No work at various practice sites without BON approval

- An informational slide show is available for employers at www.tpapn.org

- TPAPN requires that an informed supervisor be available. A supervisor is a nurse or employee with direct authority who: a) is informed of Nurse’s TPAPN participation; b) is not a current participant in TPAPN or any other state approved peer assistance program; c) if holder of state licensure, license is unencumbered; d) has been informed of this Agreement including any restrictions; and e) can respond should concerns arise about Nurse’s practice and/or behaviors.

- Employer is to contact the Case Manager during the week prior to the quarterly meetings when restrictions are due to be lifted.

- Co-workers should be informed that the program is confidential not secret. TPAPN requires that nursing co-workers with a need to know be informed of the nurses’ participation and practice restrictions. An informational slide show is available for co-workers at www.tpapn.org.

- Nurse may need accommodation for treatment, aftercare meetings, and drug testing.

- TPAPN records need to be kept in a locked file separate from the personnel file.

- Urine Drug Screens (UDS):
  - Nurse must do the following if taking abusable prescription medications:
    - Notify TPAPN verbally and send in prescription information ASAP.
    - Refrain from practice until 24 hours after taking last dose.
    - Notify Case Manager upon taking last dose.
  - Nurse may need to arrange to leave the unit for random drug screening at a local collection site.
  - Nurse will provide supervisor with Chain of Custody form to be kept with Urine Drug Screen collection kits, in case a “for-cause” drug test is needed.
  - UDS kits will be delivered to the employer at the physical address provided on the Work Agreement. Nurse must have COC’s to use kits. These test kits are to be used for the following situations:
    - If the TPAPN nurse appears impaired, or drugs are missing. Collect specimen, assess for harm to self or others, suspend from work, provide safe transport and referral to assessment/treatment as needed. Notify TPAPN case manager.

UDS KITS FROM TPAPN’S DRUG TEST ADMINISTRATOR ARE NOT TO BE USED AS A REGULAR MEANS OF TESTING.

MAKE COPIES OF THE FOLLOWING ITEMS FOR YOUR RECORDS/FAX COPIES TO TPAPN at 512-467-2620:

- TPAPN Work Agreement including Consent between Employer and Government Agencies
- Quarterly Update form
TPAPN WORK AGREEMENT

☐ WORK CONFERENCE APPROVED BY TPAPN CASE MANAGER

Please submit this Work Agreement, Consent between the Employer and Government Agencies, and the Quarterly Update immediately upon completion of this Agreement. Employer and participant should maintain copies.

PARTIES TO AGREEMENT

This (“Agreement”), 7 pages, is entered into on ____/____/___ by (“Nurse”) ___________________________ and (Participant’s Name) ___________________________.

("Employer/Facility") ___________________________ and the Texas Peer Assistance Program for Nurses (“TPAPN”), a board-approved program operating under Texas Health and Safety Code, Chapter 467. This Agreement is executed in connection with Nurse’s participation in TPAPN and all terms and conditions of Nurse’s TPAPN Participation Agreement remain in effect. In consideration of Nurse’s employment or continued employment by Employer, Nurse and Employer agree to the Terms and Conditions for Nurse’s return to work as set out in this Agreement and any TPAPN Attachments. This Agreement does not obligate Employer to employ Nurse or Nurse to work for Employer for any period stated or implied. Except as provided in this Agreement including any Attachments (Distributive Practice, CRNA Practice, and Nursing Academics), Nurse is employed on the same terms and conditions as Employer’s other employees. This Agreement is not complete unless all pages are completed and both Nurse Participant and Employer have initialed all terms and conditions in the spaces indicated. The Nurse must submit this signed Agreement immediately after its execution to TPAPN.

TPAPN NURSE PARTICIPANT INFORMATION

(Print name) ___________________________ / (Signature) ___________________________ / (Date of signing) ___________________________.

Nurse Participant’s name: ___________________________ License #: ___________________________.

Case Manager: ___________________________.

Type of Participation: Substance Use Disorder ____ Psychiatric Disorder ____ Dual Diagnosis ____

(Area of nursing ex: med/surg; dialysis; ER) ___________________________ / (Unit, Dept, or Location) ___________________________ / (Shift) ___________________________ / ___________________________.

(Name of Direct Supervisor) ___________________________.

EMPLOYER/FACILITY MAILING ADDRESS: (Print)

Name: ___________________________.

Address: ___________________________ City: ___________________________ State: __________ Zip: __________.

Facility Phone: ___________________________ Unit Phone: ___________________________ Cell Phone: ___________________________.

Supervisor’s Name: ___________________________ (Print name) ___________________________ / (Signature) ___________________________ /Date: ___________________________.

Title: ___________________________ Phone: ___________________________ Cell/Pager: ___________________________ Email: ___________________________.

ADDITIONAL CONTACTS

TPAPN typically requires additional contact persons who are informed of the nurses TPAPN participation. An informed contact is a nurse or other informed employee who: a) is informed of Nurse’s TPAPN participation; b) is not a current participant in TPAPN or any other state approved peer assistance program; c) if holder of state licensure, license is unencumbered; d) has been informed of this Agreement including any restrictions; and e) can respond by contacting supervisor should concerns arise about Nurse’s practice and/or behaviors.

Contact Name: ___________________________ (Print name) ___________________________ Title: ___________________________ Phone: ___________________________ Cell/Pager: ___________________________.

Contact Name: ___________________________ (Print name) ___________________________ Title: ___________________________ Phone: ___________________________ Cell/Pager: ___________________________.

TPAPN Advocate who facilitated this Agreement, (if applicable) ___________________________ / ___________________________ / ___________________________.

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TPAPN WORK AGREEMENT

TERMS AND CONDITIONS OF EMPLOYMENT

1. PRACTICE SETTING AND LENGTH OF TIME

1.1 TPAPN will be available for consultation as needed, to facilitate Nurse's safe return to practice.

1.2 Nurse must remain in TPAPN for one (1) to three (3) years unless the Nurse is an advanced practice registered nurse (APRN), i.e. nurse practitioner, nurse anesthetist, nurse-midwife or clinical nurse specialist, in which case the nurse must remain in TPAPN for five (5) years.

1.3 Nurse (other than an APRN) must work in nursing a minimum of sixty-four (64) hours per month for twelve (12) consecutive months while in TPAPN. The length of participation may be extended until such twelve (12) months have been completed.

1.4 APRNs must not administer anesthesia or practice prescriptive authority for the first year of documented recovery.

1.5 TPAPN shall monitor Nurse's practice for as long as Nurse participates in program.

Nurse's Initials _____ Employer's Initials _____

2. WORK PERFORMANCE AND CONDITIONS OF EMPLOYMENT

2.1 Nurse's satisfactory participation in and/or completion of the TPAPN program are a condition of Nurse's continued employment. Dismissal or withdrawal from TPAPN for any reason may be grounds for termination of Nurse's employment by Employer. TPAPN will notify Employer of Nurse's withdrawal or dismissal from TPAPN program.

2.2 Nurse's continued employment depends not only on compliance with this Agreement but also on satisfactory job performance. Unsatisfactory job performance may be grounds for termination on the same basis as other employees of Employer.

2.3 Employer agrees to notify TPAPN within two (2) days of any unsatisfactory job performance, unusual behavior at work and/or any disciplinary or performance counseling. In the event of behavior inconsistent with good recovery, the Employer will request nurse to immediately refrain from practice and notify TPAPN.

2.4 Employer agrees to notify TPAPN within one (1) day of any change in supervisor or contact(s).

Nurse's Initials _____ Employer's Initials _____

3. ABSTINENCE AND DRUG SCREENS

3.1 Nurse agrees to abstain completely from all illicit substances, controlled medications, other abusable substances and alcohol, including but not limited to those listed under the “abusables substances” section of the TPAPN Participant Handbook, except when prescribed by physician(s) authorized by TPAPN to prescribe medications for the Nurse. Nurse agrees to immediately notify Employer and TPAPN Case Manager of any controlled or abusable medications prescribed by physician(s) and provide appropriate documentation from physician. Employer and Nurse agree that Nurse will refrain from nursing practice while taking prescribed controlled or abusable medications. Nurse may continue to return to practice when authorized by TPAPN Case Manager.

3.2 Hand Sanitizers containing Ethyl Alcohol are prohibited for use by participants.

3.3 Nurse agrees to provide specimens for drug screens on a random basis as frequently as required by TPAPN or Employer. For cause specimens must maintain proper chain of custody (COC), be witnessed and collected within two (2) hours of request. The TPAPN drug testing administration program furnishes urine drug screen kits and prepaid courier bills for specimens collected by Employer.

3.4 Nurse agrees to maintain the ability to test at all times. Employer agrees to suspend Nurse from work and notify TPAPN if he or she is unable to test. Upon signing this agreement, Nurse will provide employer with two (2) COC forms for use if a for-cause drug test is needed.

3.5 In the event of a positive drug screen showing the presence of any unauthorized drug or abusable substance, Employer or TPAPN shall notify Nurse that he or she is to immediately refrain from practice unless the TPAPN Case Manager has authorized such practice.

3.6 Nurse understands and agrees that a confirmed positive drug screen is considered conclusive proof of use of the indicated substance and shall result in a review of the appropriateness of Nurse’s continued employment by Employer and continued participation in TPAPN.

3.7 Employer and TPAPN will notify each other by the end of the next business day (Monday-Friday) of receipt of a positive drug screen. Any positive drug screen report not processed by the TPAPN central laboratory and received by Employer should be submitted to TPAPN immediately.

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3.8 If Nurse is under psychiatric participation only, TPAPN can require Nurse to enroll in TPAPN’s drug screening program. TPAPN will notify Employer of such requirement.

3.9 In addition to any rights under this Agreement, the Employer reserves the right to require that Nurse to be drug tested in accordance with any drug testing policies or programs that apply to other employees.

Nurse's Initials _____ Employer's Initials _____

4. RESTRICTIONS ON PRACTICE

4.1 Experience indicates a nurse’s chance of success in TPAPN highly correlates to a supportive work environment. The restrictions set out below are required by TPAPN’s policies. TPAPN considers these to be reasonable accommodations under the Americans with Disability Act (ADA). TPAPN reviews restrictions on an individual basis to determine any exceptions or modifications to these restrictions. Any modifications must be approved by the Nurse’s TPAPN Case Manager.

4.2 Night shift work is permitted given no contraindication by Nurse’s healthcare provider.

4.3 Nurse and Employer agree to abide by these restrictions. Nurse and Employer agree to inform TPAPN immediately of any violation of these restrictions.

4.4 Nurse and Employer must indicate acceptance by initials with each restriction.

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<td>1. Nurse will not have access to controlled medications or other abusable medications during first six (6) months of work. Access includes counting or administering controlled or abusable medications, witnessing wastage, pharmacy receipt of controlled or abusable medications, or ability to access storage areas for controlled or abusable medications. Access to controlled or abusable medications after the first six-(6) months will occur only as mutually agreed upon by TPAPN and Employer. This restriction may be waived by TPAPN if nurse is participating under an agreement for psychiatric disorder only. Check box if TPAPN Case Manager has verified that restriction has been waived.</td>
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<td>2. Nurse will not be given on-call assignments during the first six (6) months of work. After six (6) months, on call assignments may be worked only if mutually agreed upon by TPAPN Case Manager and Employer.</td>
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<td>3. Nurse will not function in an autonomous or unsupervised role.</td>
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<td>4. Nurse will not work shifts longer than twelve (12) hours.</td>
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<td>5. Nurse will work on regularly assigned, predetermined unit. Floating is considered on a case by case basis.</td>
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<td>6. Nurse will not work for multiple employers or engage in self-employed practice.</td>
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<td>7. Nurse will not accept short-term employment with registries or staffing agencies or work as a traveler.</td>
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<td>8. Nurse will not work more than (96) hours per (2) week pay period.</td>
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<td>9. Nurse will not work at various practice sites, without approval from TPAPN and TX BON; considered on a case by case basis.</td>
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4.5 Modifications: The following modifications to the restrictions have been pre-approved by the TPAPN Case Manager.

Nurse's Initials _____ Employer's Initials _____
5. EMPLOYER RECORD KEEPING AND DISCLOSURE OF INFORMATION

5.1 Information relating to Nurse’s substance use and/or psychiatric disorder and participation in TPAPN acquired as a result of Nurse’s participation in TPAPN shall be maintained and disclosed by Employer only as permitted by this Agreement.

5.2 This Agreement, consents for disclosure of information, and other records relating to Nurse’s participation in TPAPN for substance use and/or psychiatric disorder shall be maintained in a confidential, secure file separate from Nurse’s personnel records and to which the personnel department does not have routine access. The file shall be prominently marked as containing confidential information that may not be disclosed except as permitted by state and federal law.

5.3 Information maintained by Employer relating to Nurse’s participation in TPAPN for substance use and/or psychiatric disorder is confidential under state and federal law including Chapter 467, Texas Health & Safety Code, "Peer Assistance Programs" and 42 CFR Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records," and may not be disclosed except as permitted by those laws and regulations. Consent by Nurse authorizing disclosure must be in writing on a TPAPN authorized form that complies with federal and state law. Any confidential records or information disclosed shall include a notation (a stamped notation is permissible) prohibiting re-disclosure without Nurse’s consent except as permitted by state and federal law.

5.4 Except as otherwise permitted by this section, upon either a) the Nurse’s completing, withdrawing or being dismissed from TPAPN or b) the Nurse’s cessation of employment, Employer shall either destroy or return to TPAPN, all copies of TPAPN agreements, consents for disclosure, and other records or information related to the Nurse’s participation in TPAPN. Employer may retain the following types of information:

1) If Employer referred Nurse to TPAPN, Employer may maintain the information about the incidents leading to the referral and indicating that Nurse was referred to an "approved state peer assistance program."

2) If Employer terminated Nurse and a substantial reason for termination was Nurse’s failure to satisfactorily participate in TPAPN, Employer may retain in the separate, confidential file described under Sec. 5.2 the following information:

i) that a substantial reason for Nurse’s termination was Nurse’s failure to satisfactorily participate in TPAPN;

ii) a copy of this Agreement and consent executed under 6.6 of this Agreement.

5.5 If Nurse engages in conduct that constitutes a violation of the laws and regulations governing the practice of nursing or Employer’s policies, this agreement does not prevent Employer from documenting, in the same manner as Employer normally documents such incidents (e.g., in Nurse’s personnel file), the facts. Nurse engaged in such conduct and how Employer dealt with that conduct provided that any documentation in the Nurse’s personnel file shall not identify the Nurse as a TPAPN participant or refer to the Nurse’s substance use disorder and/or psychiatric disorder. The Nurse’s conduct shall be immediately reported to the TPAPN Case Manager. Employer agrees to consult with TPAPN prior to reporting Nurse to the Board of Nursing because of the conduct, unless the Nurse’s conduct presents an immediate threat to the public. In such an event, Employer will notify TPAPN of the conduct immediately after making report to the Board of Nursing.

Nurse’s Initials _____ Employer’s Initials _____

6. CONSENT FOR DISCLOSURE OF INFORMATION

6.1 Nurse consents to the disclosure of information as set out in this Agreement and to execute any needed release of information or consent forms. Failure to execute required consents shall result in dismissal from TPAPN.

6.2 To facilitate Nurse’s recovery and safe nursing practice, Nurse authorizes Employer, Nurse’s healthcare providers, and TPAPN to share with each other any information regarding the Nurse’s substance use disorder, psychiatric disorder, and/or any unsatisfactory job performance.

6.3 Prior to Nurse assuming nursing duties, employer agrees to direct Nurse’s immediate coworkers to view TPAPN coworker slide show, available at www.tpapn.org, This applies to coworkers who have a legitimate need to know Nurse’s status in TPAPN and related practice restrictions.

6.4 Employer agrees to inform personnel responsible for staffing and scheduling including house supervisor as appropriate, regarding Nurse’s work restrictions.

6.5 Employer, as appropriate, agrees to inform PRN/Float/Pool/Agency nursing staff who work with Nurse about Nurse’s restriction to controlled medications or other abusable medications.

6.6 Nurse agrees to disclose his/her participation in TPAPN to immediate coworkers who have a legitimate need to know, in order to provide a safe and more supportive work environment, prior to assuming nursing duties.

6.7 Re-disclosure of Participation/Work Agreement by Employer. If Employer terminates Nurse, in substantial part, because of Nurse’s failure to satisfactorily participate in TPAPN, and the Nurse files a claim for unemployment benefits or a legal claim alleging inappropriate termination, Nurse authorizes the Employer to disclose to the Texas Workforce Commission, other governmental agency or court adjudicating the claim that a substantial reason for terminating the Nurse was failure to satisfactorily participate in TPAPN. Nurse agrees to execute an appropriate consent authorizing such disclosure (see page 6 & 7 of this Agreement).

Nurse’s Initials _____ Employer’s Initials _____
7. MEETINGS WITH EMPLOYER

7.1 A TPAPN QUARTERLY UPDATE must be completed at the same time that the initial TPAPN Work Agreement is signed. Starting from the signing of the Work Agreement, Nurse and Employer, will meet every three months thereafter to complete the QUARTERLY UPDATE in order to document Nurse's recovery progress and work performance. Any modifications to work restrictions will be addressed at the time of the QUARTERLY UPDATE and must be approved by the TPAPN Case Manager prior to the meeting. The TPAPN Advocate cannot modify this Agreement; however, the TPAPN Advocate can state that verbal approval was received from the Nurse’s TPAPN Case Manager.

Nurse's Initials _____ Employer's Initials _____

8. MODIFICATIONS TO AGREEMENT

8.1 No modifications to this Agreement or any attachment shall be effective until approved by the Nurse, Employer and TPAPN.

Nurse's Initials _____ Employer's Initials _____

9. NOTICE OF ATTACHMENTS

9.1 The Following Attachment if checked applies to this agreement and is executed in conjunction with this agreement. Check beside appropriate addendum or if not applicable, write N/A and initial.

Distributive Practice e.g., (Home Health, School Health & Multiple Practice Sites) _____
CRNA Practice _____
Nursing Academics _____
Pain Management _____

Nurse's Initials _____ Employer's Initials _____

CONSENT TO DISCLOSE INFORMATION BETWEEN EMPLOYER AND GOVERNMENTAL AGENCIES REGARDING TERMINATION FOR NONADHERENCE IN TPAPN CONTINUED ON PAGES 6 & 7
TPAPN WORK AGREEMENT

TPAPN AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN EMPLOYER AND GOVERNMENTAL AGENCIES REGARDING TERMINATION FOR NONADHERENCE IN TPAPN (SEE SECTION 6 OF TPAPN WORK AGREEMENT)

I understand a condition of my participation in the Texas Peer Assistance Program for Nurses (“TPAPN”) is that I authorize my employer to use and disclose my Protected Health Information (“PHI”) to certain governmental agencies. I further understand that if I add or change employers, I will need to execute additional authorizations. Nurses who decline to sign this Authorization or such additional authorizations are not eligible to participate in TPAPN.

I, (print name) ____________________________________________________________ authorize

(name of participant)

my employer, ___________________________________________________________ (“EMPLOYER”)

(name of employer)

(Contact person & address) __________________________________________________

to use and disclose my PHI for purposes other than treatment, payment, or health care operations. I specifically authorize EMPLOYER or EMPLOYER’S designated employee(s) and agents to disclose my PHI, as identified below, to (collectively “TWC/COURT/AGENCY”):

1. Texas Workforce Commission
2. The judge of a court adjudicating a claim by me for unemployment benefits or wrongful termination
3. Other: ________________________________________________________________

(name of government agency)

I understand that by signing this authorization, EMPLOYER and TWC/COURT/AGENCY may communicate with each other and exchange information (including information obtained from third-parties) relating to my participation in TPAPN and how my unsatisfactory participation relates to my termination from employment, including, but not limited to:

• The terms and conditions of my Work Agreement under TPAPN;
• Any substantial reason for my termination related to my failure to satisfactorily participate in TPAPN;
• Information related to my substance use disorder and/or psychiatric disorder and participation in TPAPN; and
• Information about the incidents leading to the referral including information indicating I was referred to an “approved state peer assistance program.”

I authorize EMPLOYER and TWC/COURT/AGENCY to disclose my PHI electronically.

I understand that my record may include information about my diagnosis and treatment for substance use disorder and/or psychiatric disorder, and other sensitive information that is protected by federal and/or state law.

I understand that federal law generally prohibits re-disclosure of substance abuse treatment without my consent.

RE-DISCLOSURE OF INFORMATION:

I understand that there is a potential for information disclosed pursuant to this authorization to a non-health care entity to be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations.

I release TPAPN from any liability for such re-disclosure(s).

PURPOSE OF DISCLOSURE:

EMPLOYER will use and share my PHI with TWC/COURT/AGENCY in order to facilitate full disclosure of all relevant information related to:

• A claim for unemployment benefits
• A legal claim alleging wrongful termination; or
• Other:

(Form continues on next page)
TPAPN WORK AGREEMENT

TPAPN AUTHORIZATION TO DISCLOSE INFORMATION BETWEEN EMPLOYER AND GOVERNMENTAL AGENCIES REGARDING TERMINATION FOR NONADHERENCE IN TPAPN (SEE SECTION 6 OF TPAPN WORK AGREEMENT)

REVOCATION:

I understand that I can revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it.

I understand EMPLOYER is relying on this Authorization in employing or continuing to employ me while I am a participant in TPAPN and may disclose the information covered by this Authorization even if I revoke this Authorization. In the event of adjudication of a claim by me for either unemployment benefits or wrongful termination, EMPLOYER may notify TWC/COURT/AGENCY of my unsatisfactory participation in TPAPN or that I withdrew or was dismissed from the program even if I revoke this Authorization. I specifically authorize such disclosures even after my revocation of this Authorization.

I understand that I may revoke this Authorization only in a signed, written revocation provided EMPLOYER via certified U.S. mail addressed to EMPLOYER c/o the contact person and address identified above or other address or facsimile EMPLOYER instructs me to use. The written revocation must include the following information:

- My name and address, TPAPN case number, and Texas nursing license number;
- TWC/COURT/AGENCY’s name and address as set out above;
- Date I signed this Authorization as set out below; and
- My intent to revoke this authorization.

Unless a later date is specified in the revocation, the revocation will be effective at the close of the next business day following receipt by EMPLOYER.

If not previously revoked, this authorization will terminate 60 days after final adjudication of any claim, including appeals; I file for unemployment benefits or for wrongfully termination against EMPLOYER.

ACKNOWLEDGEMENT

I have read this authorization and understand what information will be used or disclosed or re-disclosed, who may use, and re-disclose the information, the recipient(s) of that information, and the circumstances in which my PHI will be disclosed/re-disclosed even after my written revocation.

Participant’s Printed Name: __________________________

Participant’s Signature: __________________________

Date: __________________________ Case Number: __________________________

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS: Substance use disorder information disclosed by TPAPN pursuant to this Authorization is required by federal law to include the following notice:

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
TPAPN Quarterly Update

This form is to be completed when you sign your WORK AGREEMENT and every three (3) months thereafter. Failure to complete and submit this form every 3 months may result in an extension of your TPAPN participation.

CHECK ONE:
□ This is a routine Quarterly Update. (None of the conditions listed below apply)
□ This is a New Employer. (Quarterly must be accompanied by the TPAPN Work Agreement)
□ This is a New Nurse Manager or supervisor who has reviewed and understands the original Work Agreement.
□ This is a Quarterly following an EXTENSION or RENEWAL of TPAPN with current employer (There is no need for a new Work Agreement). A new Quarterly Update must be completed upon returning to work after an extension. All terms of the original Work Agreement still apply and restrictions are reinstated.

NURSE PARTICIPANT’S INPUT

1. Employed in nursing: □ Part time hours/month _______________ □ Full time hours/ pay period or week ____________

2. Unit or Work location: ________________________________ Unit phone #: ___________________ Shift: _______________

3. Area of practice: __________________________________________________________________________________________

4. Your psychiatrist’s name is: __________________________________________________________________________________
   Last date seen: _______________ Next scheduled appointment: _______________ Phone #: _______________

5. Your therapist’s name is: ____________________________________________________________________________________
   Last date seen: _______________ Next scheduled appointment: _______________ Phone #: _______________

6. List all currently prescribed medications: ________________________________
   __________________________________________________________________________________________________________

7. Primary Care Physician: Name: ___________________________________ Phone #: ___________________

8. List any other physicians/dentists/therapists you have seen in the last 3 months that have not been previously listed: __________
   __________________________________________________________________________________________________________

Healthcare Provider consent was faxed to TPAPN for this new physician/dentist/therapist: _______ Consent form was not faxed but faxing it now _______.

9. How often will you contact your TPAPN nurse advocate next quarter? □ weekly □ q 2 weeks □ monthly

10. Have you had any problems following your practice restrictions this past quarter? Y ___ N ___ If yes, explain: ______________ ____________________________________________________________________________

11. The next quarterly meeting to be scheduled with employer and advocate (or case manager) will be: _______________________

Participant’s Signature: ___________________________________ Date: ___________________
ADVOCATE'S INPUT

TPAPN Advocate’s Name (Print) __________________________ Not Present: _____ Present: In Person_____ By Phone_____

1. How often did this nurse agree to call you this quarter? __________________________________________________________

2. How often did this nurse call you this quarter? __________________________________________________________________

3. Did you have a face-to-face meeting with the nurse this quarter? : Y___ N___ If not, why? _______________________________

   Additional Comments: _________________________________________________________________________________________

   Advocate’s Signature (if present): _________________________________________________ Date: __________

EMPLOYER’S INPUT

- To be completed by a nurse manager or supervisor who has read and understands the Work Agreement. -

PLEASE COMPLETE THE FOLLOWING CHECKLIST BY CIRCLING Y, N, or N/A AS APPROPRIATE

**If this is the first quarterly being completed with an initial WORK AGREEMENT, please circle N/A for all questions below. **

1. Does this nurse notify you of changes in medications? Y N N/A__________________________

2. Do you currently have drug specimen collection kits available? Y N N/A__________________________

3. If needed, has this nurse been able to leave work for drug screens? Y N N/A__________________________

4. Have there been any job performance concerns in the past 3 months? Y N N/A__________________________

5. Have there been any problems enforcing practice restrictions this quarter? Y N N/A__________________________

   Additional Comments: _________________________________________________________________________________________

   Supervisor Name (Print): __________________________ Title/Position: __________________________

   Supervisor Name (Signature): __________________________ Date: ________________

Facility: _____________________________________________________________________________________________________

Address: _______________________________________________City: _____________________ State: _____ Zip code: _________

Phone #: ____________________Cell/Pager: _______________________Email: __________________________________________

Other individual(s) present: ___________________________________Title:_______________ Phone No:  _____________________

Other individual(s) present: ___________________________________Title:_______________ Phone No:  _____________________

Is Case manager present by phone conference?  Y___  N___ Case Manager Name ________________________________________

PRACTICE RESTRICTIONS CAN ONLY BE MODIFIED WITH TPAPN CASE MANAGER PERMISSION.

Advocate or employer can obtain this permission from the Case Manager.

Note the date below that the restrictions were modified:

NARCOTICS: ___________________ ON CALL: __________________________NIGHTS: __________________________

See Section 4.2 of the Work Agreement
TPAPN Quarterly Update

This form is to be completed when you sign your WORK AGREEMENT and every three (3) months thereafter. Failure to complete and submit this form every 3 months may result in an extension of your TPAPN participation.

CHECK ONE:
☐ This is a routine Quarterly Update. (None of the conditions listed below apply)
☐ This is a New Employer. (Quarterly must be accompanied by the TPAPN Work Agreement)
☐ This is a New Nurse Manager or supervisor who has reviewed and understands the original Work Agreement.
☐ This is a Quarterly following an EXTENSION or RENEWAL of TPAPN with current employer (There is no need for a new Work Agreement). A new Quarterly Update must be completed upon returning to work after an extension. All terms of the original Work Agreement still apply and restrictions are reinstated.

NURSE PARTICIPANT’S INPUT

1. Employed in nursing: ☐ Part time hours/month ___________ ☐ Full time hours/ pay period or week ___________
2. Unit or Work location: _______________________________ Unit phone #: ___________________ Shift: _______________
3. Area of practice: __________________________________________________________________________________________
4. Your psychiatrist's name is: __________________________________________________________________________________
   Last date seen: _______________ Next scheduled appointment: ______________ Phone #: ___________________
5. Your therapist’s name is: ____________________________________________________________________________________
   Last date seen: _______________ Next scheduled appointment: ______________ Phone #: ___________________
6. List all currently prescribed medications: _________________________________________________________________
   _________________________________________________________________________________________________
7. Primary Care Physician: Name: ___________________________________________________________ Phone #: _______________
8. List any other physicians/dentists/therapists you have seen in the last 3 months that have not been previously listed: __________
   _______________________________________________________________________________________________

Healthcare Provider consent was faxed to TPAPN for this new physician/dentist/therapist: _______ Consent form was not faxed but faxing it now _______.

9. How often will you contact your TPAPN nurse advocate next quarter? ☐ weekly ☐ q 2 weeks ☐ monthly
10. Have you had any problems following your practice restrictions this past quarter? Y___ N____ If yes, explain: _________________________________

11. The next quarterly meeting to be scheduled with employer and advocate (or case manager) will be: ______________________

Participant's Signature: ___________________________________________ Date: ___________________
ADVOCATE’S INPUT

TPAPN Advocate’s Name (Print) ________________________________ Not Present: _____ Present: In Person _____ By Phone _____

1. How often did this nurse agree to call you this quarter? _______________________________________________________

2. How often did this nurse call you this quarter? __________________________________________________________________

3. Did you have a face-to-face meeting with the nurse this quarter? : Y___ N___ If not, why? _______________________________

Additional Comments: _________________________________________________________________________________________

Advocate’s Signature (if present): ___________________________________________ Date: __________

EMPLOYER’S INPUT

- To be completed by a nurse manager or supervisor who has read and understands the Work Agreement. -

** If this is the first quarterly being completed with an initial WORK AGREEMENT, please circle N/A for all questions below. **

1. Does this nurse notify you of changes in medications? Y   N   N/A__________________________

2. Do you currently have drug specimen collection kits available? Y   N   N/A__________________________

3. If needed, has this nurse been able to leave work for drug screens? Y   N   N/A__________________________

4. Have there been any job performance concerns in the past 3 months? Y   N   N/A__________________________

5. Have there been any problems enforcing practice restrictions this quarter? Y   N   N/A__________________________

Additional Comments: _________________________________________________________________________________________

Supervisor Name (Print): __________________________________ Title/Position: ____________________

Supervisor Name (Signature): __________________________________ Date: ________________

Facility: _____________________________________________________________________________________________________

Address: __________________________________________________________________________ City: __________________ State: _____ Zip code: _________

Phone #: ____________________ Cell/Pager: _______________________ Email: __________________________________________

Other individual(s) present: ___________________________________ Title:_______________ Phone No:  _____________________

Other individual(s) present: ___________________________________ Title:_______________ Phone No:  _____________________

Is Case manager present by phone conference? Y___    N___ Case Manager Name ________________________________________

PRACTICE RESTRICTIONS CAN ONLY BE MODIFIED WITH TPAPN CASE MANAGER PERMISSION.

Advocate or employer can obtain this permission from the Case Manager.

Note the date below that the restrictions were modified:

NARCOTICS: ___________________ ON CALL: __________________________ NIGHTS: __________________________

See Section 4.2 of the Work Agreement
Addendum to TPAPN Work Agreement
For Distributive Practice Settings (e.g., Home Health & School Health)

Indicate area of practice: ____ Home Health ____ School Nurse ____ Other distributive practice (type):_________________________

Instructions:
- Nurse, TPAPN (case manager or advocate) and Employer (nursing director, manager/supervisor) are to review and initial this addendum along with the TPAPN WORK AGREEMENT (attach addendum to agreement).
- Employer and Nurse are to contact TPAPN case manager about questions/concerns before signing forms.
- If an accommodation is not applicable, write “N/A” and initial.
- Nurse and Employer are to initial items 1 –5 (below) and then sign and date form.
- Nurse and Employer should keep signed copies of work agreement, addendum and other work agreement forms.
- Nurse is to submit the work agreement and addendum to TPAPN with other work agreement forms.
- TPAPN recommends that Nurse assumes office duties or divides time between office and supervised field duties for at least the initial 2-4 weeks of orientation; after orientation, Nurse will report to office once daily for face-to-face meetings with Employer.

Initial all that apply or mark “N/A” on items that do not apply:

1. In all distributive practice areas, all terms and conditions of the TPAPN WORK AGREEMENT will be met; e.g., meetings with Employer on a monthly and quarterly basis; self-help meetings, drug testing, and restrictions on practice (see Section 4 of agreement).
   Nurse _____ Employer _____

2. If participating for substance use disorder or dual diagnosis, Nurse will not access or administer controlled and/or abusable substances for the first six months of employment (see Section 4 of the work agreement for detailed description of this restriction). A Nurse working in home health will not accept or be assigned pain management or oncology cases for at least the first six months of employment.
   Nurse _____ Employer _____

3. Nurse will not accept overtime or on-call for 1st six months. Since overtime is restricted, Nurse and Employer agree that Nurse’s caseload will not exceed that which can be managed within a 40-hour work week. (Before modifying overtime or on-call restrictions, Nurse’s case must be reviewed with Employer and Case Manager at the end of six months of employment. Modification of on-call restriction can be considered when appropriate nursing supervision is available.)
   Nurse _____ Employer _____

4. Nurse must not work autonomously. Nurse must check-in with Employer, at least twice each working day at beginning and end of shift. One check-in must be face-to-face; the other can be by phone call. A record of these daily meetings must be kept and submitted to TPAPN each month.
   Nurse _____ Employer _____

5. Nurse must not work unsupervised. Employer must be willing to make unannounced visits to Nurse’s practice sites at least once monthly for the first six months, then at least once every other month for the second six months, then per Employer’s policy thereafter. Employer is encouraged to increase the frequency of monitoring when possible, e.g., by making telephone calls to Nurse’s clients/families as quality assurance checks - to inquire as to client’s satisfaction with the quality of their nursing care. (In school nurse setting, school principals or assistant principals must be available for quality assurance checks.)
   Nurse _____ Employer _____

6. If participating under mental illness only and working in home health, Nurse will not accept or be assigned any home health psychiatric cases for at least the first year of employment.
   Nurse _____ Employer _____

Nurse’s Signature___________________________________________________ TPAPN Case# _________ Date ___________________

Employer’s signature ______________________________________________ _______________________ Date ___________________
# NURSING SUPERVISION DAILY SIGN-IN LOG

HOME HEALTH_______ OTHER______________

(Submit completed form monthly to TPAPN Case Manager/Contact TPAPN immediately if problems arise)

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SUPERVISOR (Print)___________________________________________ Signature________________________________________

FACILITY NAME______________________________________________________________________________________________

NURSE NAME (Print) _________________________________________ Signature ________________________________________

C/o Texas Nurses Foundation, 8501 N. MoPac Expy., Ste. 400 • Austin, TX • 78759 • 1-800-288-5528 • FAX 512/467-2620 • www.tpapn.org
NURSING ACADEMIC PROGRAM CONSENT

NOTE: This authorization/consent form ("Authorization") is to be used only exchange of information between the Texas Peer Assistance Program for Nurses/Mental Health Support Program/Extended Evaluation Program collectively known as TPAPN/MHSP/EEP, hereafter referred to as “TPAPN” and nursing academic program.

I understand a condition of my participation TPAPN is that I authorize TPAPN to use and disclose my Protected Health Information ("PHI") to any nursing academic program in which I am enrolled. I further understand that if I enroll in other nursing academic programs, I will need to execute additional authorizations. Nurses who decline to sign this Authorization or such additional authorizations are not eligible to participate in TPAPN/MHSP/EEP.

I, (print name) authorize

(name of participant) authorize

TPAPN to use and disclose my PHI for purposes other than treatment, payment, or health care operations. I specifically authorize TPAPN or TPAPN designated employee(s) to disclose my PHI, as identified below, to the academic program listed ("PROGRAM"):

Nursing Academic Program: _______________________________ Phone: _______________________

(name of program)

Address: __________________________ City: __________ State: _____ Zip: _______

(address of program)

I understand that by signing this authorization, TPAPN and PROGRAM may communicate with each other and exchange all information (including information obtained from third-parties) relating to my participation in TPAPN and my enrollment in the PROGRAM including, but not limited to, my:

• Status in TPAPN including nonadherence, e.g., withdrawal or dismissal;
• Return to academics (clinical and classroom) accommodations;
• Academic performance;
• Ability to practice nursing;
• My inability to remain abstinent from all abusable substances.

I understand that TPAPN typically communicates with the immediate dean or director of PROGRAM and faculty, and nurses at the clinical site who oversee my clinical activities as I progress through the academic program, if I am nonadherent.

I authorize TPAPN and PROGRAM to disclose my PHI electronically.

I understand that my record may include information about my diagnosis and treatment for substance use disorder and/or psychiatric disorder, and other sensitive information that is protected by federal and/or state law.

I understand that federal law generally prohibits re-disclosure of substance abuse treatment without my consent.

RE-DISCLOSURE OF INFORMATION:

I understand that there is a potential for information disclosed pursuant to this authorization to a non-health care entity to be subject to re-disclosure by the recipient and no longer be protected by state or federal privacy regulations.

I further understand that by disclosing information to PROGRAM, PROGRAM may disclose my information to faculty members and nurses at the clinical site who have a legitimate need to know and authorize such disclosures.

I release TPAPN/MHSP/EEP from any liability for such re-disclosure(s).

PURPOSE OF DISCLOSURE:

TPAPN will use and disclose my PHI with PROGRAM in order to facilitate:

• Participation in TPAPN,
• Recovery from any problems I may be experiencing with psychiatric or other behavioral disorder or medical condition and
• My ability to continue or return to nursing academics/practice in a manner that is conducive to safe patient care.

(Form continues on next page)
NURSING ACADEMIC PROGRAM CONSENT

REVOCATION:

I understand that I can revoke this Authorization in writing at any time except to the extent that action has been taken in reliance on it.

I understand TPAPN is relying on this Authorization in permitting me to participate in TPAPN and may disclose the information covered by this Authorization even if I revoke this Authorization. In the event I withdraw or am dismissed from TPAPN, TPAPN may notify PROGRAM that I have withdrawn or been dismissed even if I revoke this Authorization and that PROGRAM likewise may notify TPAPN if I am performing unsatisfactorily in, have been dismissed or leave the academic program even if I revoke this Authorization. I specifically authorize such disclosures even after my revocation of this Authorization.

I understand that I may revoke this Authorization only in a signed, written revocation provided via certified U.S. mail addressed to TPAPN c/o Texas Nurses Foundation, 8501 N. MoPac Expy., Ste. 400, Austin, TX 78759 or facsimile addressed to TPAPN at 512-467-2620 or such other address or facsimile TPAPN instructs me to use. The written revocation must include the following information:

- My name and address, TPAPN case number, and Texas nursing license number;
- PROGRAM name and address as set out above;
- Date I signed this Authorization as set out below; and
- My intent to revoke this authorization.

Unless a later date is specified in the revocation, the revocation will be effective at the close of the next business day following receipt by TPAPN.

If not previously revoked, this authorization will terminate 60 days after I complete, withdraw or am dismissed from TPAPN.

ACKNOWLEDGEMENT

I have read this authorization and understand what information will be used or disclosed or re-disclosed, who may use, and re-disclose the information, the recipient(s) of that information, and the circumstances in which my PHI will be disclosed/re-disclosed even after my written revocation.

Participant’s Printed Name:______________________________________________________________

Participant’s Signature:______________________________________________________________

Date:__________________________________________ Case Number:__________________________
Addendum to TPAPN Work Agreement
For Student Enrollment in Nursing Academic Programs
(A new Addendum must be completed at the beginning of each semester or quarter.)

Instructions:
- This Addendum is to be attached to the completed WORK AGREEMENT. All Work Agreement terms are to be adhered to including any modifications approved by TPAPN. The term “Nursing Academic Program” is to be substituted for “Employer” in the WORK AGREEMENT.
- The WORK AGREEMENT and Addendum are to be reviewed and signed by the Participant (referred to as “Nurse”) and the designated Nursing Academic Program Representatives “NAPRs”, which includes the Nursing Faculty who oversees the Nurse’s clinical rotations, and the Nurse Preceptor, if applicable, at the student clinical site.
- The NAPRs and Nurse are to discuss the entire Work Agreement document, including this Addendum with the Nurse’s TPAPN Case Manager prior to signing.
- Nurse and NAPRs are to initial where applicable, then sign and date Addendum.
- A new Addendum must be signed whenever there is a change of NAPR’s or clinical site.
- This Addendum shall be effective when approved by TPAPN under the modifications and attachment sections of the Work Agreement, see item 9.1 of TPAPN Work Agreement.
- Nurse is to ensure that this Addendum is completed with the WORK AGREEMENT.
- Nurse is to submit the WORK AGREEMENT and Addendum to TPAPN.
- Nurse and NAPRs are to keep copies of the entire WORK AGREEMENT and Addendum.

1. Nurse and Nursing Academic Program agree that the Nurse’s course/clinical work hours combined with any employment hours do not exceed 96 hours per 2 week time period.

   Nurse’s Initials_________ Faculty NAPR’s Initials________ Preceptors Initials________ (if applicable)

2. Nurse must check in face-to-face with his or her clinical faculty or preceptor before, during and after each clinical day.

   Nurse’s Initials_________ Faculty NAPR’s Initials________ Preceptors Initials________ (if applicable)

3. This Clinical rotation is expected to end as of: _________ (mo/day/yr)

4. Nurse and NAPRs agree to inform TPAPN of Nurse’s ongoing academic pass/fail status by the end of each academic semester or quarter. If unacceptable clinical performance occurs, the student may be required to, cease clinicals and obtain re-evaluation.

   Nurse’s Initials_________ Faculty NAPR’s Initials________ Preceptors Initials________ (if applicable)

5. The identified nursing faculty member must inform the immediate Dean or Director of the Nursing Academic Program of the Student nurses participation and this form.

   Nurse’s Initials_________ Faculty NAPR’s Initials________ Preceptors Initials________ (if applicable)

   Nurse’s Signature_________________________________________________________ Date __________________

   NAPR’s (Clinical Faculty’s) Signature_________________________________________ Date __________________

   Clinical Site Nurse Preceptor’s Signature_______________________________________ Date __________________

   NAPR’s (Dean or Director’s) Signature_________________________________________ Date __________________
Addendum to TPAPN Work Agreement
For Return to Anesthesia Practice

The following guidelines are intended to facilitate the nurse’s return to work in anesthesia by providing a re-orientation period and increased monitoring in the early stages of the return.

I __________________________________________________________ understand that the very nature of anesthesia practice will place me in the (TPAPN Participant-Print Name)
unavoidable position of having access to controlled substances and/or the administration of these substances. Therefore, I agree to comply with the following practice conditions: (Participant to initial each of the conditions)

____ I will undergo an orientation time of (specify time and conditions/supervision during orientation): ____________________________________
________________________________________________________________________________________________________________________

____ During orientation, the call schedule will be (specify type of call and frequency, also frequency of late shifts): __________________________
________________________________________________________________________________________________________________________

____ After the orientation period, my call schedule will be modified to (specify): ______________________________________________________
________________________________________________________________________________________________________________________

____ I agree to random drug testing through TPAPN at least weekly (for a minimum of 6 months). After six months my supervisor and TPAPN case manager can evaluate and change the number of tests through TPAPN.

____ I also agree to be randomly drug tested by my employer on a frequency to be determined by my supervisor/employer.

____ I agree to surrender my controlled substance record and supply on demand for random inspection.

____ I will not have access to the department’s narcotics except as is absolutely necessary to provide anesthesia care to assigned cases.

____ I will not access the supplies on other units. Should I need controlled substances from other units, appropriate nursing personnel will dispense them to me and I will return all unused portions to the same dispensing nurse.

____ I will strictly adhere to the pharmacy department’s policies and procedures with regard to the dispensing, recording and returning of controlled substances.

____ I will maintain a comprehensive list of patients who have received controlled substances while in my care, both as the primary and as a relieving CRNA. This list will be provided monthly or as often as requested by my supervisors.

____ I agree to allow my supervisors immediate access of my personnel locker for inspection on demand to verify compliance with this agreement.
    I agree that I will not keep any type or form of medical supplies, e.g., medications, syringes, needles, narcotics or related paraphernalia in my locker.

____ I will not engage in the practice of exchanging my supply of controlled substances with any other CRNA, MD or other healthcare professional.

____ I will continue to comply with all TPAPN requirements relating to recovery and the Work Agreement.

____ I understand that a violation of any terms of this addendum constitutes a violation of the TPAPN Work Agreement.

Nurse's Signature _________________________________________________________________________ Date _______________

Employer's Signature ___________________________________________________________ ___________ Date _______________

Hospital Representative ____________________________________________________________________ Date _______________
(If CRNA is not directly employed by hospital)