Form 9

Ohio Board of Nursing *www.nursing.ohio.gov*
17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

MENTAL HEALTH PROFESSIONAL REPORT

As the treating practitioner, the Board of Nursing Compliance Unit requests that you please take a few moments to complete this form. **Please submit the report directly to the Compliance Unit Monitoring Agent.**

(check one)

Nurse's Name _____ Initial report _____

Progress report _____

Name of Provider (please print) _____

Address _____

Phone ( ) _____ Fax ( ) _____

Please describe nurse's progress relative to the treatment plan. Include current status and progress made.

_____

_____

Medications prescribed _____

_____

Results of drug screens (if applicable) _____

FOR INITIAL REPORTS ONLY (UNLESS CHANGES OCCUR):
Nurse's diagnosis (if appropriate) _____

_____

Please describe treatment plan for this nurse. _____

_____

For initial report only: Have you received copy of the nurse's Consent Agreement or Board Order?
YES ____NO____

_____
Practitioner signature/ Date

FORM MAY BE PHOTOCOPIED

NUR 6508