



Katie Hobbs
Governor

Joey Ridenour
Executive Director

Arizona State Board of Nursing

1740 West Adams Street, Suite 2000

Phoenix, AZ 85007-2657

Phone: (602) 771-7800

Homepage: <http://www.azbn.gov>

QUESTIONNAIRE DUE BY:

Attn:

PLEASE PRINT IN INK OR TYPE

THIS QUESTIONNAIRE WILL NOT BE ACCEPTED IF FILLED OUT IN PENCIL

Take time to read each question carefully and then answer it to the best of your knowledge. Do not leave any questions unanswered. Attach additional sheets, if necessary. The questionnaire will be returned to you if it is not filled out appropriately.

NAME: _____ DATE: _____

ADDRESS: _____

PHONE: HOME (____) _____ WORK: (____) _____

RN #: _____ LPN #: _____ NP CERTIFIED #: _____

RECOVERY HISTORY

Have you completed a drug/alcohol rehabilitation program?

No Yes (if yes, complete the following)

Inpatient Outpatient

Date of entry: _____ Date of completion: _____

Send documentation of proof of completion

Have you completed an aftercare program?

No Yes (if yes, complete the following)

Date of entry: _____ Date of completion: _____

Send documentation of proof of completion

Have you participated in a nurse recovery group?

No Yes (if yes, complete the following)

When did you join the nurse recovery group? _____

Name of the group facilitator: _____

(Have facilitator send documentation with date of entry, attendance, certification and progress)

How often do you attend the group? _____

How has the group helped you with your recovery? (be specific)

Have you participated in a twelve-step program (AA or NA)?

No Yes (if yes, complete the following)

When did you begin your twelve-step program? _____

How often do you attend meetings? Weekly More than once a week Monthly
 Other _____

Do you have a home group?

No Yes (if yes, complete the following)

Name of Home Group: _____

Do you have a sponsor? No Yes (if yes, complete the following)

How long have you had this sponsor? _____

How often do you meet and/or have contact with your sponsor?

Have your current sponsor write a letter to the Board addressing the length of time he/she has been your sponsor, addressing your twelve-step activities and their general impression of your recovery status. The Board respects the twelve-step anonymity and the sponsor letter then need only be signed with their first name. If your sponsor is willing to release their phone number, ask them to submit it.

How many sponsors have you had within the last three years?

Have you completed the twelve steps? No Yes

(If "No" what step are you on?) _____

Have you read the Big Book? No Yes

If you have not completed reading the Big Book, what chapter are you on?

How has this program helped you with your recovery? (be specific)

If you have not participated in a twelve-step program, have you participated in an alternative program such as Rational Recovery or any other program?

- No
- Yes (if yes, complete the following)

Briefly describe the function of the program and how it has benefited you in recovery.

Since you have had your license, have you had any drug screens?

- No Yes (if yes, submit copies of results of drug testing)

Since you have had your license, have you been evaluated by an addictionist?

- No Yes (if yes, send documentation)

Evaluations by an addictionist must include a complete history and physical, laboratory test and an interview evaluation.

Since you have had your license, have you been evaluated by a relapse prevention counselor?

- No Yes (if yes, send documentation)

If yes, what are your relapse warning signs? (be specific)

Since you have had your license, have you had any counseling for your substance abuse problem?

- No Yes (if yes, send documentation)

Describe your recovery program (include your support system)

MEDICAL HISTORY

Describe any current acute or chronic medical problems (include hospitalization, surgery, fractures, accidents, dental work, emergencies (give dates; be specific)

Describe any acute or chronic medical problems occurring during the past five years (include hospitalization, surgery, fractures, accidents, dental work, emergencies (give dates; be specific)

List all current prescription, self-prescribed and over-the-counter medications. For prescription medication, list name of the prescribing provider, name of medication, reason for medication, date of prescription.

Do you have one primary care provider?

No Yes (if yes, give name and address of provider)

Does the above provider know of your chemical dependency?

No Yes

If you are currently on any narcotics, non-narcotic analgesics, hypnotics, or any mood-altering medications, have the provider who prescribed write a letter to the Board stating reason for prescription, length and expected use, and addressing their knowledge of your chemical dependence.

How would you describe your current health status?

CURRENT SUBSTANCE ABUSE HISTORY (legal and/or illegal)

Current alcohol and/or drug use (check all that are applicable)

STIMULANTS

- Alcohol
- Cocaine
- Amphetamines
- Nicotine
- Caffeine

INHALANTS

List use

CANNABIS

- THC
- Marijuana
- Hashish

ANABOLIC STEROIDS

List use

NARCOTIC ANALGESICS:

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> codeine based | <input type="checkbox"/> methadone | <input type="checkbox"/> fentanyl (sublimaze) |
| <input type="checkbox"/> darvon | <input type="checkbox"/> morphine | <input type="checkbox"/> talwin |
| <input type="checkbox"/> demerol | <input type="checkbox"/> opium | <input type="checkbox"/> tylox |
| <input type="checkbox"/> dilaudid | <input type="checkbox"/> percocet | <input type="checkbox"/> vicodan |
| <input type="checkbox"/> heroin | <input type="checkbox"/> percodan | <input type="checkbox"/> other (specify) |

NON-NARCOTIC ANALGESICS:

- | | | |
|---------------------------------|---------------------------------|--|
| <input type="checkbox"/> nubain | <input type="checkbox"/> stadol | <input type="checkbox"/> other (specify) |
|---------------------------------|---------------------------------|--|

HYPNOTICS:

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> chloral hydrate (noctec) | <input type="checkbox"/> halcion | <input type="checkbox"/> nembutal |
| <input type="checkbox"/> soma | <input type="checkbox"/> phenobarbital | |
| <input type="checkbox"/> other (specify) | | |

ANTI-ANXIETY:

- | | | |
|----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> ativan | <input type="checkbox"/> tranxene | <input type="checkbox"/> xanax |
| <input type="checkbox"/> librium | <input type="checkbox"/> valium | <input type="checkbox"/> other (specify) |

HALLUCINOGENS:

- | | | |
|------------------------------------|--|----------------------------------|
| <input type="checkbox"/> LSD | <input type="checkbox"/> PCP | <input type="checkbox"/> STP MOA |
| <input type="checkbox"/> Mescaline | <input type="checkbox"/> other (specify) | |

What was your drug(s) of choice (including alcohol)? _____

PAST SUBSTANCE ABUSE HISTORY (legal and/or illegal)

Past alcohol and/or drug use (check all that are applicable)

STIMULANTS

- Alcohol
- Cocaine
- Amphetamines
- Nicotine
- Caffeine

INHALANTS

List use

CANNABIS

- THC
- Marijuana
- Hashish

ANABOLIC STEROIDS

List use

NARCOTIC ANALGESICS:

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> codeine based | <input type="checkbox"/> methadone | <input type="checkbox"/> fentanyl (sublimaze) |
| <input type="checkbox"/> darvon | <input type="checkbox"/> morphine | <input type="checkbox"/> talwin |
| <input type="checkbox"/> demerol | <input type="checkbox"/> opium | <input type="checkbox"/> tylox |
| <input type="checkbox"/> dilaudid | <input type="checkbox"/> percocet | <input type="checkbox"/> vicodan |
| <input type="checkbox"/> heroin | <input type="checkbox"/> percodan | <input type="checkbox"/> other (specify) |

NON-NARCOTIC ANALGESICS:

- | | | |
|---------------------------------|---------------------------------|--|
| <input type="checkbox"/> nubain | <input type="checkbox"/> stadol | <input type="checkbox"/> other (specify) |
|---------------------------------|---------------------------------|--|

HYPNOTICS:

- | | | |
|---|--|-----------------------------------|
| <input type="checkbox"/> chloral hydrate (noctec) | <input type="checkbox"/> halcion | <input type="checkbox"/> nembutal |
| <input type="checkbox"/> soma | <input type="checkbox"/> phenobarbital | |
| <input type="checkbox"/> other (specify) | | |

ANTI-ANXIETY:

- | | | |
|----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> ativan | <input type="checkbox"/> tranxene | <input type="checkbox"/> xanax |
| <input type="checkbox"/> librium | <input type="checkbox"/> valium | <input type="checkbox"/> other (specify) |

HALLUCINOGENS:

- | | | |
|------------------------------------|--|----------------------------------|
| <input type="checkbox"/> LSD | <input type="checkbox"/> PCP | <input type="checkbox"/> STP MOA |
| <input type="checkbox"/> Mescaline | <input type="checkbox"/> other (specify) | |

What was your drug(s) of choice (including alcohol)? _____

How were the drugs listed on pages 9-10 obtained? (be specific)

prescription abuse No Yes

diversion No Yes

street purchase No Yes

writing your own Rx No Yes

presenting illegal Rx No Yes

other (explain) _____

How long have you been clean of prescription or illegal drugs?

_____ days _____ months _____ years

How long have you been sober?

_____ days _____ months _____ years

Do you smoke cigarettes and/or have any other tobacco usage?

No Yes (if yes, describe use)

OTHER ADDICTIONS (if in current or past counseling for any, send documentation)

food shopping shoplifting

relationships gambling sex

other none of the above

EMPLOYMENT HISTORY:

Name of Employer: _____

Employer's Address: _____

Job title: _____

Supervisor: _____

Phone No.: _____

Date of Hire: _____

Is supervisor aware of your substance abuse problem? No Yes

If you are currently employed, have your supervisor write a letter on their letterhead stationery to the Board addressing the length of time of your employment, attendance record, and their general evaluation of your performance. (If you have been employed by more than one agency within the last 18 months, have each supervisor write to the Board as instructed above.

List the places you have been employed for the past 3-5 years.

1. Name of Employer: _____

Employer's Address: _____

Job title: _____

Supervisor: _____

Phone No.: _____

Start Date: _____ End Date: _____

Were you terminated or did you resign in lieu of termination from previous employment?

Yes No

If yes, please explain or note your reason for leaving: _____

2. Name of Employer: _____

Employer's Address: _____

Job title: _____

Supervisor: _____

Phone No.: _____

Start Date: _____ End Date: _____

Were you terminated or did you resign in lieu of termination from previous employment?

Yes No

If yes, please explain or note your reason for leaving: _____

3. Name of Employer: _____

Employer's Address: _____

Job title: _____

Supervisor: _____

Phone No.: _____

Start Date: _____ End Date: _____

Were you terminated or did you resign in lieu of termination from previous employment?

Yes No

If yes, please explain or note your reason for leaving: _____

LEGAL HISTORY (current and past)

In the past, or currently, have you been on civil or criminal probation?

No Yes (if yes, briefly explain reason for probation).

Also have your probation office write a letter to the Board stating the reason for your probation, length of time and your compliance with your probation requirements.

Have you ever been arrested while driving under the influence of drugs and/or alcohol?

No Yes (if yes, explain when, where and disposition of arrest)

Have you engaged in illegal activities in order to obtain drugs?

No Yes (if yes, explain)

Have you ever been arrested for possession of illegal drugs?

No Yes (if yes, explain when, where and disposition of arrest)

LICENSE INFORMATION:

Have you ever had any disciplinary action on your license in Arizona or any other state?

No Yes ____

If yes, briefly explain why for each state in which the discipline occurred and the current disposition of your license in that state.

What do you like least about being a nurse?

AFFIDAVIT

STATE OF _____

County of _____

The undersigned being duly sworn declares that he/she is the person referred to in the foregoing application; that the statements are true in every respect; that he/she has not suppressed any information that would affect this application: that he/she will conform to the ethical standards of conduct in the profession of nursing; and that he/she has read and understands this affidavit.

SIGNATURE

SUBSCRIBED AND SWORN to before me this _____ day of _____, 202__.

Commission Expires:

Date

Notary Public

Notary Seal