Monthly Self Report

- ☐ KARE
- ☐ Probation

Instructions: Please fill out this form completely and mail the completed form to the Compliance Section, Consumer Protection Branch, *by the tenth (10th) of each month*. The original form is being supplied to you. Make a supply for your use by copying this one. Please copy the form front to back.

General Information

Name	Month/Year	Case Manager
Address	City, State	Zip Code
Home Phone Number	Work Phone Number	Cell Phone Number
E-mail address:		

1. Have you changed your name, address, or phone number(s) in the past month?
   ☐ No ☐ Yes
   If yes, has the information been submitted to the Kentucky Board of Nursing?
   ☐ No ☐ Yes

Employment Information

Are you currently employed? ☐ Yes ☐ No Are you currently on leave? ☐ Yes ☐ No	Is this a nursing position? ☐ Yes ☐ No What shift do you work?	Status ☐ Full time ☐ Part Time # of hours per week:
Name of Facility where employed		Telephone Number of Facility
Facility Address		City, State, Zip Code
Supervisor's Name and Title	Supervisor's direct number, pager, etc.	

2. Is your employer aware that you are being monitored by the Compliance Section, Consumer Protection Branch, Kentucky Board of Nursing?
   ☐ No ☐ Yes

3. Have you experienced any change with your employer, employment status, shift, work hours, supervisor, work restrictions or responsibilities?
   ☐ No ☐ Yes

Do your present duties involve dispensing or handling controlled substances? If yes, please check how you administer the medication: ☐ under direct observation ☐ with supervision ☐ without supervision	☐ Yes	☐ No
Have you been sanctioned or disciplined at work and/or is your job in jeopardy? *If yes, please explain.*	☐ Yes	☐ No
Have you had any special issues or problems with your job? *If yes, please explain.*	☐ Yes	☐ No

Name: ______________________________

Medical Information

Name of Primary Healthcare Practitioner	Last Appointment Date	
Address of Facility	Telephone Number	
Are you currently being treated for any physical/medical condition? If yes, what is the diagnosis?	☐ Yes	☐ No

Please list below any and all medication (prescriptions (prescribed or samples), over the counter medication, vitamins, etc) that you are currently taking and/or have taken this month:					
Date of Prescription	Name of Medication	Dosage	Quantity Dispensed	Number of Refills	Diagnosis

4. Is your healthcare practitioner(s) aware that you are being monitored by the Compliance Section, Consumer Protection Branch, Kentucky Board of Nursing?
   ☐ No ☐ Yes

Treatment

Are you currently working with a treatment professional for chemical dependency, psychiatric or personal issues? (If yes, complete the information below.)	☐ Yes	☐ No
Name of Counselor/Psychiatrist/Psychologist	Last Appointment Date	
Name of Facility	Telephone Number	
Address	City, State, Zip Code	

5. Is your treating practitioner aware that you are being monitored by the Compliance Section, Consumer Protection Branch, Kentucky Board of Nursing?
   ☐ No ☐ Yes

6. What level of treatment are you engaged in at this time?
   ☐ Residential ☐ IOP ☐ Aftercare/Continuing Care
   ☐ Group ☐ Individual ☐ Other: ________________________

7. How do you feel you are progressing?
   ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Not doing well

Name: ______________________________

Self-help

Are you currently participating in any self-help program (AA, NA, Emotions Anonymous, Gamblers Anonymous, etc)?	☐ Yes	☐ No
Are you working through the 12 steps? If yes, what step are you working on this month?	☐ Yes	☐ No

Do you have a sponsor? If yes, what is your sponsor's name: If yes, how often do you communicate with your sponsor?	☐ Yes	☐ No

Are you concerned about your emotional well-being? (Experiencing depression, isolating, etc.) *If yes, please explain.*	☐ Yes	☐ No

Within the month, have you experienced cravings and/or using dreams? *If yes, please explain.*	☐ Yes	☐ No
Have you relapsed? If yes, have you reported the relapse to your case manager? ☐ Yes ☐ No *If no, please explain*	☐ Yes	☐ No
Do you have a sobriety date? If yes, what is your sobriety date?	☐ Yes	☐ No

Legal

Are you currently working with an attorney? If yes, complete the information below.	☐ Yes	☐ No
Name of Attorney	Telephone Number	
Address	City, State, Zip Code	

8. Is your attorney aware that you are being monitored by the Compliance Section, Consumer Protection Branch, Kentucky Board of Nursing? ☐ No ☐ Yes

Court Ordered Monitoring

Are you currently being monitored on court ordered probation, drug court or diversion? (If yes, complete the information below.)	☐ Yes	☐ No
Name of Probation/Parole Officer, Drug Court or Diversion Counselor	Telephone Number	
Address	City, State, Zip Code	

9. Is your Probation/Parole Officer, Drug Court Counselor/Diversion Counselor, aware that you are being monitored by the Compliance Section, Consumer Protection Branch, Kentucky Board of Nursing? ☐ No ☐ Yes

Name: ______________________________

Pending Legal Charges

Have you been arrested, charged, or convicted of a crime other than a minor traffic offense this month? (If yes, please attach documentation)	☐ Yes	☐ No
If you answered yes to the above question, have you reported the event to the Kentucky Board of Nursing? (If no, please attach documentation)	☐ Yes	☐ No
If you currently have legal action pending against you, what is the status of your court case?		

Other

Do you have any questions, concerns or comments regarding Affinity? If yes, please explain.	☐ Yes	☐ No	☐ N/A

Have you completed CE courses, *if required*, this month? If yes, please submit the appropriate documentation.	☐ Yes	☐ No	☐ N/A

Have you made payments towards your civil penalty/hearing fee, *if required*, this month?	☐ Yes	☐ No	☐ N/A

Do you have any questions, concerns or comments for your case manager? If yes, please explain below.	☐ Yes	☐ No

Explanations/Questions/Comments (*please do not leave this section blank*)

I certify that the information contained in this monthly self report is true, complete and accurate.

______________________________ ______________________

Participant signature Date

4/19/2010
jmc