
Street Address

City State Zip

**DIVERSION PROGRAM
FOR CHEMICALLY DEPENDENT NURSES**

C O N T R A C T

I, _____, Nursing License No. _____, recognize and admit that I have an alcohol or a substance use disorder and desire to enroll in the NM Board of Nursing's Diversion Program (DP) for Chemically Dependent Nurses. I agree to be monitored through the program for a period of five (5) years. During this period, I understand I will be required to periodically meet with representatives of the program for an evaluation of my progress in recovery. **I also understand that my contract with the DP may be amended periodically dependent upon my progress in recovery.**

I, hereby, waive any time limitations contained in the Uniform Licensing Act, including but not limited to Section 61-1-3.1 and 61-1-4. **Nurses in the DP are not eligible for multi-state privilege according to Section 16.12.6.9 NMAC. I understand my license will be changed to a single state practice only upon signing this contract.**

The conditions of my contract with the Diversion Program are as follows:

1. I agree to admission into a drug/alcohol treatment program, in-patient or intensive out-patient. I agree to participate in one year aftercare program and other counseling as determined necessary.

Treatment Program: _____
Aftercare Program: _____
Therapist: _____

2. I shall ensure that my therapist will submit written reports to the DP describing her/his initial assessment of my status and motivation. My therapist shall notify the DP, in writing, when I have been discharged from the aftercare program. My therapist shall also notify the DP, in writing, if I fail to complete the aftercare program or don't comply with treatment or abstinence. Any change in my therapist shall be immediately reported to the DP.
3. The Regional Advisory Committee or DP Coordinator may recommend that I re-enter individual/group counseling after completion of initial treatment. I also understand that I must obtain prior approval from DP before going out of town or on vacation.
4. **I agree to participate in** _____ support group meetings per week, i.e. AA, NA or another recognized group (preferably 12-step group) which provides support for recovery from addictions (minimum of three (3) meetings per week required) and agree to work the 12-steps with **my sponsor**, _____ and have my sponsor sign off on each of my completed 12-step attendance forms. I will submit the 12-step attendance forms monthly confirming my attendance at 12-step meetings. My sponsor will report any noncompliance and/or discharge to the DP.
5. I will submit monthly, written reports to the DP describing my own evaluation of my progress in recovery.

6. I agree to ensure that my immediate nursing supervisor will read and sign this contract, schedule routine check in meetings, and will report any concerns and/or change in work status to the DP as requested. **I am employed at _____ and my immediate nursing supervisor is _____.**
 - a. If any change in employment occurs I will ensure my new employer sends a letter of hire within two weeks, verifying they read contract and stipulations. I agree to notify the DP within two days of any change in supervisor or employment position in writing and I will provide the new nursing supervisor with a copy of this contract and any contract amendments.
7. I agree to submit voluntarily, without questions, and within twelve (12) hours of notification to random, observed drug/alcohol screens which shall be done according to the DP protocol. A report of the drug screens shall be submitted each month. The DP Coordinator or RAC may also request a urinary drug screen at any time, within any time frame designated. If I miss any drug screen, it is a violation of my contract. I agree to immediately notify the DP Coordinator if I miss any drug screens. **My drug screens will be managed by _____.**
8. **I will inform my significant other(s): _____, of the conditions of this contract.**
9. I shall immediately inform the DP Coordinator or Executive Director of the Board of Nursing if I relapse (any unauthorized use of drugs or alcohol).
10. I, hereby, give permission to my therapist, sponsor, health care provider(s), immediate nursing supervisor or significant other to contact the DP, if there is ever any concern about my recovery. Likewise, I give permission to the DP representative to contact any of the above persons regarding my recovery.

11. The following summary of written reports must be received by the Diversion Program by the 20th of each calendar month in which reports are due. **Only fax reports acceptable to confidential DP fax number: 505-841-9092.**

	NAME	FREQUENCY OF REPORTS
Drug Screen Coordinator:	_____	_____
Self Reports:	_____	_____
12-Step attendance sheet -with sponsor signature and comments:	_____	_____
Therapist:	_____	_____
Nursing Supervisor:	_____	_____

12. **DRUG(S) OF CHOICE:** _____.
13. Describe conditions regarding access to controlled substances in my practice of nursing: e.g. administration of narcotics, and possession of narcotic keys: _____

14. **LIST OF CURRENT MEDICATIONS:** A letter verifying prescriptions must be received from physician within ten (10) days of any prescription: _____.
15. **OVER-THE-COUNTER MEDICATIONS:** _____.
16. I understand that if I have chronic pain and am being treated with Opiates that I shall be evaluated by a pain clinic or pain specialist and must have a complete neuropsychological evaluation **and** clearance from my practitioner before continuing or returning to practice. Section 16.12. 9.9 NMAC.

17. Describe any conditions of this contract not previously addressed: _____

MANDATORY REEVALUATION SCHEDULED FOR: _____
Assigned Committee /Town Date Time am/pm

LOCATION: _____

WITHIN TWO (2) WEEKS:

I agree to obtain all required signatures, **AND** submit this contract to the DP Coordinator. A copy of the signed contract will be returned to me.

I, the undersigned, have read and agree to participate in this nurse's recovery. I agree to maintain confidentiality of this nurse's participation in the DP.

SIGNIFICANT OTHER SIGNATURE	DAY TELEPHONE #	DATE
AA/NA SPONSOR SIGNATURE	DAY TELEPHONE #	DATE
DRUG SCREEN COORDINATOR SIGNATURE	DAY TELEPHONE #	DATE
THERAPIST SIGNATURE	DAY TELEPHONE #	DATE
NURSING SUPERVISOR SIGNATURE	DAY TELEPHONE #	DATE
NURSE ADMINISTRATOR SIGNATURE	DAY TELEPHONE #	DATE

I understand that this is a **NO-USE** contract and that my participation in the DP is conditional upon my complete abstinence from alcohol, marijuana, cocaine, stimulants, narcotics, sedatives, tranquilizers, and all other mind-altering and/or potentially addicting drugs, including over the counter medications. In the event such drugs may be needed as a legitimate part of my medical care, I will immediately notify the DP Coordinator. I will inform my healthcare provider, that if mind-altering drugs are prescribed, a letter must be submitted within ten (10) days to the DP explaining the choice and length of treatment.

I give permission for my personal health care provider(s) to release information to the DP and authorize the DP coordinator to contact my personal health care provider as deemed necessary. Following are listed my health care providers during the past two (2) years.

(1) _____ (2) _____

I will inform my personal health care provider(s) of the conditions of this contract and request that they not prescribe any mind-altering drugs for me unless there are no other reasonable alternatives.

HEALTH CARE PROVIDER SIGNATURE	DAY TELEPHONE #	DATE
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I understand that aggregate data may be extrapolated from my file for research purposes, and that no identifying information will be used. I agree to have my data used for research Yes No

I understand that in the event I breach any of the terms of my Diversion Program contract, my nursing license may be summarily suspended, I may be required to immediately return my nursing license to the Executive Director of the Board of Nursing. I understand that, if I am summarily suspended, I will be afforded a formal hearing before the Board of Nursing within ninety (90) days of the summary suspension in accordance with the Uniform Licensing Act, Sections 61-1-1 through 61-1-33 NMSA 1978. I understand if the Board takes disciplinary action against my license, the confidentiality provisions no longer apply and I may be asked to sign a new DP contract.

NURSE PARTICIPANT SIGNATURE	DOB	SOCIAL SECURITY #	PHONE #	DATE
DIVERSION PROGRAM CASE MANAGER				DATE
DIVERSION PROGRAM COORDINATOR				DATE
EXECUTIVE DIRECTOR				DATE