

*****SAMPLE ONLY*****

DIVERSION PROGRAM CONTRACT AMENDMENT

*Nurse: Obtain required signatures and return original by mail within 2 weeks Attn: DP Coordinator

NURSE PARTICIPANT: _____ LIC. NO: _____ New Address: YES

Street address _____ City _____ State _____ Zip code _____

MEETING DATE: _____ or DATE MAILED: _____ COMMITTEE: _____

This meeting was held for a routine evaluation of licensee's progress in recovery and participation in the Diversion Program. Licensee's monitoring reports shall be submitted to the Diversion Program according to the following frequency schedule:

	<u>Name</u>	<u>Frequency of Reports</u>
Drug Screens:	_____	_____
Self-Reports:	_____	_____
12-Step Form (Sponsor):	_____	_____
Therapist/Reports:	_____	_____
Nursing Supervisor/Reports:	_____	_____

Disciplinary Status: _____

Practice Restrictions: _____

Comments: _____

Nurse Participant Signature _____ Date _____
Day Telephone: _____

NEXT SCHEDULED MEETING DATE / TIME

Counselor/Therapist Signature _____ Date _____
Day Telephone: _____

Committee Member Signature _____ Date _____

Nursing Supervisor Signature _____ Date _____
Day Telephone: _____

Sponsor Signature _____ Date _____
Day Telephone: _____

Drug Screen Coordinator Signature _____ Date _____
Day Telephone: _____

Significant Other Signature _____ Date _____
Day Telephone: _____