ARKANSAS STATE BOARD OF NURSING
DEPARTMENT OF ENFORCEMENT

TREATMENT PROVIDER REPORT

Licensee: _____ License No.: _____

Due Dates: _____

Monitored Nurse to fill in the **months** the reports are due. All documentation must be submitted by the 10th of the months listed.

Licensee is required to submit a Treatment Provider Report every three (3) months. Please complete and give to licensee to submit or if you chose you may send directly to the Board at ASBN.monitoring@arkansas.gov.

Primary Treatment Focus: _____

Secondary Treatment Focus: _____

Medication	Indication	Dosage & Frequency	Number of Refills

Please use the back of this form if you need additional space to list medications.

Participant's current diagnosis: _____

Has there been any change in participant's diagnosis? If yes, please explain: _____

_____

Participant's treatment plan, recommendations, and interventions: _____

_____

_____

_____ _____

(Treatment Provider signature) (Print name and title)

_____ _____

(Date) (Phone number)

Instructions for Licensee if report given to you by provider:

- Licensee **with Affinity** drug monitoring account – upload signed document in your Affinity account under Documentation / Reports / Available Reports / Add Attachment
- Licensee **without** drug monitoring – please email to ASBN.monitoring@arkansas.gov