

Montana Nurses Assistance Program

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MONTANA NURSES ASSISTANCE PROGRAM CONTRACT

I (Jane Doe), have elected to participate in the Non-Disciplinary Tract of NAP and abide by the following conditions set forth in this contract. I understand that regardless of a final stipulation being determined by the Montana Board of Nursing, that I am to follow the terms of this contract unless otherwise directed by the aforementioned final stipulation. I understand that all forms referred to in this contract are found in the *NAP Participant Handbook*.

While participating in the NAP program I agree:

1. To participate in the Non-Disciplinary tract of NAP for a minimum of three years, pending final stipulation from the Board of Nursing. I agree to abide by the terms of this contract and the *NAP PARTICIPANT HANDBOOK*, which represents policy and procedure of the NAP. Further, I agree to adhere to any new policies and procedures that I receive in writing from the NAP office.

Regarding Alcohol and Drug Use and Abuse, I agree:

2. To completely abstain from the use of alcohol (regardless of abuse diagnosis) and **all products containing alcohol** in addition to all mood altering drugs or scheduled medications. I understand that prescription medications are allowable as long as they are prescribed by my primary medical practitioner, and monitored by the same. I understand that I must have my practitioner complete a *Medication Verification Form*, which is to be sent directly to the NAP office. This form must be in the NAP office within 5 (five) days of the date of prescription. The *Medication Log* must be filled out by me and sent to the NAP office to confirm dosing within 5 (five) days of the last dose, and weekly while using the medication. I understand that all unused scheduled medications must be disposed of in my private practitioner's office and verification of such be provided by them via the *Medication Form*.
3. To receive a full Chemical Dependency Assessment to be completed by a Licensed Addiction Counselor (LAC). I understand that I am to follow through with all recommendations resulting from this assessment. In its' directive from the Montana BON, NAP must endorse all treatment recommendations.
4. To report any alcohol or drug relapse, regardless of the amount ingested, to the NAP office within 48 hours of its' occurrence. Relapse is defined as any unauthorized use of scheduled drugs, or alcohol.

5. To be re-assessed by a Licensed Addiction Counselor in the case of a relapse, (where addiction has been diagnosed) as appropriate, to determine if additional treatment is indicated. I understand that I am to follow through with all recommendations resulting from this assessment.
6. To abide by further recommendations in the event of a relapse, as deemed clinically appropriate by the NAP consultant.
7. To attend a minimum of 1 (one) 12-Step or equivalent support group meeting per week and provide documentation to the NAP office via the *Support Group Verification Form*. This form is to be sent to the NAP office on a quarterly basis along with other quarterly reports forms due from me.
8. To select one primary health care provider for my health care needs (must be provided within 10 days of my admission to NAP if not current).
9. To select one pharmacy for prescription needs (must be provided within 10 days of my admission to NAP if not current).
10. To notify NAP immediately if I seek medical care, am hospitalized, or must undergo any procedures requiring the administration of any scheduled drug.

Regarding Random Urinalysis, I agree:

11. To submit urine for random testing according to the NAP schedule of collections.

I understand that I am to call the toll free number to Rocky Mountain Monitoring, Monday through Friday, before 11 AM to determine the collection color for that day. When my color is scheduled for collection, I understand that I am to go to:

Enter clinic name and address

I understand that my color is:

BLUE: 4 specimens submitted per four week period; 2 being sent for analysis
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My color may change based upon several variables, including but not limited to:

- Return to nursing
- Compliance history
- Relapse
- Six months of complete compliance history

I agree to pay the UA collection fee at the time of service to my UA collector.

Further, I understand that I am to pay for the cost of drug screen analysis in advance to Rocky Mountain Monitoring. Full payment for screens is to be post marked by the 23rd of each month for the following months' drug screens

(Example: Payment for the month of May to be post marked by April 23). Late or delinquent payments to RMM will result in *non-compliance*, and endanger my ability to continue with random UA tests, which could ultimately lead to my being discharged from NAP.

12. To have my supervisor call the NAP office in the case that I am not able to leave work for my scheduled urine collection on the day of my scheduled collection. Additionally, my supervisor must send written documentation within 3 (three) days of the missed screen. Any unauthorized missed drug screens will be considered as a positive result and *non-compliance* will be issued. Noncompliance with drug screens will result in an increased level of testing and may also result in a report to the Montana BON.
13. That any confirmed positive drug screen may be considered a relapse if the NAP office has not received the proper documentation from my prescribing practitioner. If I disagree with the positive drug screen result, or am denying use of unauthorized substances, I understand that my case may be referred to the Montana Board of Nursing. In this circumstance, the appropriateness of my continued involvement with NAP will be determined on a case-by-case basis by NAP staff. Noncompliance with drug screens will result in an increased level of testing and may also result in a report to the Montana BON.
14. That if I experience chronic pain issues, I am to have a full assessment completed by a Medical Doctor *approved by NAP* that has sub-specialty training in Addictions and Pain Management. I understand that I will need to sign and adhere to a Pain Management Contract, which take into consideration the recommendations of the aforementioned assessment.

Regarding Administrative Requirements, I agree:

15. To return all Quarterly Report Forms to the NAP office by the deadline indicated on the face sheet that is sent out with the set of forms. I agree to give the employer and counselor forms to these respective individuals with consideration of time needed to complete said forms and return them directly to the NAP office. I understand that Quarterly Reports that are not returned to the NAP office by the deadline will cause me to be out of compliance with NAP Program requirements.
16. To notify the NAP office within 5 (five) calendar days of any change in my home, employment, or other addresses or phone numbers.
17. To sign all releases of information relevant to my treatment, healthcare, and participation in the NAP program.
18. To appear in person for any requested interview with reasonable notice given by NAP.

19. That any and all expenses incurred while I am a participant in the NAP are my responsibility, and are considered in my overall success of the NAP.
20. To inform NAP verbally and in writing of a pending relocation out of the state of Montana. Prior to my relocation, I understand that I must be enrolled in that state's equivalent Nurses Monitoring Program, as well as provide documentation to NAP that the state's Board of Nursing has been informed of my involvement with the Montana Nurses Assistance Program.
21. That NAP will disclose my entry and compliance with the NAP program to other states I am licensed in.
22. To immediately notify the NAP office if I am arrested or convicted of any crime, regardless of its' relation to alcohol or drug offenses.
23. To notify NAP within 5 (five) days if a complaint has been filed with the Montana Board of Nursing or any other Board of Nursing. If participating in the Non-Disciplinary Tract of NAP, I understand that this will result in my participation in NAP being reported to the Montana Board of Nursing for use in the consideration of the complaint.
24. To notify NAP within 2 (two) working days if I have had a disciplinary meeting or employment counseling with my employer, or if I have resigned or been terminated from a nursing position.
25. To have voice messaging activated via machine or service at my home number for the duration of my involvement with NAP.
26. To attend *all* scheduled meetings of the Nurses Support Groups. Absences are allowed only with written documentation from my primary medical care practitioner who must describe the condition causing my inability to attend. This documentation must be received within 3 (three) days of the missed meeting.

Nurses Support Group Meetings:

I will be attending the MISSOULA Nurses Support Group and agree to call the meeting facilitator listed below to introduce myself within 5 (five) days of my admission to NAP:

Sue Richards 452-2700

I understand that it is my responsibility to call the facilitator to confirm dates for all meetings.

I will be in attendance to the Annual Statewide NAP meeting that will be scheduled for _____ . Meeting location:

Regarding Working as a Licensed Nurse, I agree:

27. To inform any and all employers or schools that I may be employed by or associated with of my participation in the NAP.
28. To submit a job description to the NAP office for all potential nursing positions for NAP approval. I understand that failure to do so may result in my having to terminate my position or employment.
29. To provide a copy of this NAP contract along with any and all stipulations and/or final orders from the Montana Board of Nursing to any prospective or current nursing position employer.
30. To provide a *Supervisor Instruction and Agreement Form* signed by my direct supervisor PRIOR to beginning or resuming a new or existing position. I understand that failure to provide this to the NAP office will result in an immediate cease and desist of all work related activities order from NAP until such a time as the *Supervisor Instruction and Agreement Form* is received in the NAP office.
31. That the following work restrictions apply when working as a licensed nurse; I:
 - a. Will not work in the following areas;
 - i. Registry
 - ii. Traveling Nurse
 - iii. Float Pool
 - iv. Temporary Employment Agency Work
 - v. Home Based Setting
 - b. Will not work more than 92 hours in any 2 (two) week period;
 - c. Will not work shifts within 12 hours of each other;
 - d. Will not work more than 3 (three) 12 hours shifts in a four day period;
 - e. Will not accept a supervisory position;
 - f. Will not work for more than one employer;
 - g. Will abide by all policies, procedures, and contracts of my employer;
 - h. Will ONLY work for a supervisor who has signed and returned the *Supervisor Instruction and Agreement Form* and who has been given a copy of this NAP contract;
 - i. Will notify the NAP office immediately of any change in my supervisor;
 - j. Will schedule monthly check-in meetings with my supervisor for the purpose of addressing any concerns of either party. These meetings must be documented and such made available to the NAP office upon demand.
 - k. Understand, I must maintain continuous employment in a full time nursing position (20 or more hours per week), for at least one year of the three year contract, to be eligible for successful discharge from NAP.

32. To put any exceptions to the above outlined work restrictions in writing and submit to the NAP office prior to any position acceptance, job responsibility change, or other related employment activity.

33. To not have access to or administer controlled substances or any potentially addictive medications for the first 6 months I return to work.

In Summary:

34. I understand that if I am non-compliant with any of the terms of this contract in any respect, the NAP consultant may notify my employer and that the length and terms of this contract may be extended and modified.

35. I understand that if I am non-compliant with the terms of this contract, I may be discharged from the NAP program.

36. I understand that non-compliance with any of the terms of this contract is considered a violation of the Nurse Practice Act as stipulated by the State of Montana.

37. I understand that if I am discharged from the NAP for non-compliance, the Montana Board of Nursing may use any misconduct that may have occurred while enrolled in NAP in disciplinary proceedings, and the Montana Board of Nursing may obtain my complete records of participation in NAP.

I have read this contract, and have had an opportunity to ask questions regarding the terms of this contract. Any modifications to the terms of this contract are subject to the approval of the NAP Consultant and must be documented in an addendum signed by the NAP participant and the NAP Consultant.

Emery Jones, LCPC, LAC
NAP Consultant

Date

NAP Participant Signature

Date

NAP Participant Printed Name