OKLAHOMA BOARD OF NURSING **Telephone: 405/962-1800**
P.O. Box 52926 **Facsimile: 405/962-1819**
Oklahoma City, OK 73152 **Website: http://www.oklahoma.gov/nursing**

PRESCRIBER MEDICATION REPORT

NURSE NAME: _____
(Print Name)

Please complete the form below. **Please send the completed form directly to the Oklahoma Board of Nursing office. The completed form must be mailed or faxed by the Prescriber's office only.** If you have any questions, please call the Oklahoma Board of Nursing at (405) 962-1827.

PRESCRIPTION INFORMATION (Please print and complete all boxes.)

Date of Prescription	Name of Medication	Dosage	Frequency	Number Prescribed	Number of Refills	Detailed Reason Prescribed
***Example:* 7/1/2023**	**Percocet**	**7.5 mg 1 tab**	**every 4-6 hrs as needed**	**30 tabs**	**None**	**Left hip pain**
1.						
2.						
3.						
4.						
5.						

I have been informed this nurse is being monitored by the Oklahoma Board of Nursing. I declare and affirm that the information documented on this form is true, complete and correct.

_____ _____
Prescriber Name (Please Print) Prescriber Signature

_____ _____
Prescriber Office Phone Number Date

I, _____ hereby authorize _____ to disclose to the Oklahoma Board of Nursing, including staff and Oklahoma Board of Nursing Board members, any and all information relating to medical treatment which may be requested.

_____ _____ _____ _____
Nurse signature Date Witness signature Date