**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**

# NURSE'S INITIAL MEDICATION REPORT

**NURSE NAME**: _____
(Print name)

**To be completed by the nurse within 10 days of receipt of the Board Order.** Report all medication(s) being taken to include prescription medications, over-the-counter medications, and/or recommendations for use of any marijuana product(s). If you have any questions, please call the Oklahoma Board of Nursing at (405) 962-1827.

## PRESCRIPTION AND/OR OVER-THE-COUNTER ("OTC") MEDICATION(S)

(Please print and complete all boxes as appropriate.)

| Date Prescribed and/or OTC Taken | Name of Medication | Dosage | Frequency | Number Prescribed | Detailed Purpose | Name of Prescribing Healthcare Provider ("Prescriber") |
|---|---|---|---|---|---|---|
| *Example:* **7/1/2023** | **Levothyroxine** | **.025 mg 1 tab** | **Daily** | **30 tabs** | **Thyroid disease** | **John Doe, M.D.** |
| *Example:* **7/1/2023** | **Tylenol PM** | **500mg/ 25mg 1 tab** | **Bedtime 3 times per week** | **OTC** | **Sleep** | **OTC** |
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |
| 6. | | | | | | |
| 7. | | | | | | |
| 8. | | | | | | |

I declare and affirm that the information documented on this form is true, complete and correct. I understand that any false or misleading information shall be cause for the nurse's appearance before the Board.

_____ _____
(Nurse signature) Date

**Please complete in the designated online compliance system, mail, scan, or fax (405) 962-1819 to the Board office. Please be advised that a verbal report will NOT be accepted.**

**Please refer to the Board's Body Fluid Testing Guidelines when completing the Nurse's Initial Medication Report.**