



545 MAINSTREAM DRIVE, SUITE 414 * NASHVILLE, TENNESSEE 37228-1219 * 615-726-4001 FAX: 615-726-4003 * WWW.TNPAP.ORG

Advocacy/Diversion Program Transfer

Instructions to Licensee

- Complete Section A only.
- After completing Section A, submit the entire form (Section A and B) to advocacy/diversion program or state licensure board **from** which you are requesting **to transfer**.

SECTION A {PRINT INFORMATION}

Name	_____	Profession	_____	License No.	_____
Street Address	_____				
City	_____	State	_____	Zip Code	_____
Home phone #	_____	Mobile phone #	_____		
Date of birth	_____	Social Security #	_____		
Email address	_____				

REFERRAL DATA

Leaving program (state)	_____	Contact person/title	_____		
		Phone #	_____		
		Fax #	_____		
		Consent form received (date)	_____		

Entering program (state)	_____	Contact person/title	_____		
		Phone #	_____		
		Fax #	_____		
		Consent form received (date)	_____		

List all state licenses (currently/previously)	_____	Profession & License No.	_____		
	_____		_____		
	_____		_____		
Reason for referral to diversion/assistance program	_____				

Formal discipline taken by any Board of Nursing? Yes No If yes, state _____
If yes, date _____ Explain.

FAMILY/SOCIAL HISTORY

Married Divorced Separated Single

Name of spouse/significant other _____

Number of children and ages _____

MEDICAL HISTORY

Current medications _____

Medical illnesses (recent) _____

Mental health diagnosis _____

Primary Physician _____

Address _____

Phone Number _____

EMERGENCY CONTACT

Name _____

Address _____

Telephone _____

Relationship _____

Please attach a copy of the following documents:

- Professional license for each and every state that you hold or have held a license/certification.
- Tennessee license
- Evaluation
- Treatment Discharge Summary
- TnPAP Authorization to Exchange Information

I attest that the above information is accurate.

Signature _____ Date _____



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SECTION B {PRINT INFORMATION}

Instructions to Advocacy Program or Board of Nursing

- Complete Section B.
- After completing Section B, mail or fax to TnPAP along with supporting documentation.

ENROLLMENT INFORMATION

Date enrolled in program _____

Formal discipline taken by any Board of Nursing? Yes No If yes, attach copy of Order.

Number of previous A&D treatment(s) _____

Number of previous mental health treatment(s) _____

Drug(s) of choice:

1. _____
2. _____
3. _____

Clean & sober since _____

Number of Relapses while in program _____

Date of last Relapse _____

Previous DUI/arrest/convictions related to A&D Yes No

If yes, explain _____

Diverted drugs from workplace? Yes No

If yes, explain _____

CHEMICAL ABUSE/DEPENDENCY TREATMENT HISTORY

Primary treatment (inpatient/outpatient) lists date and facility

Type	Date	Facility	Diagnosis

MENTAL HEALTH TREATMENT HISTORY

Primary treatment (inpatient/outpatient) lists date and facility

Type	Date	Facility or Therapist	Phone Number

Current attending counseling? Yes No Frequency _____

Name _____

Address _____

Telephone _____

TOXICOLOGY HISTORY

Frequency _____ Random _____ Scheduled _____ Number collected _____ Number positive _____

Toxicology noncompliance history (list number and reasons) No shows _____ Refusals _____

PROGRAM STATUS SUMMARY

Type/frequency of reports requested by diversion/assistance program _____

History of non-compliances _____

Noncompliance work related issues _____

List of work restrictions _____

Nurse support group attendance? Yes No Frequency _____

Documented attendance? Yes No

History of noncompliance? Yes No

AA/NA support group attendance? Yes No Frequency _____

Documented attendance? Yes No

History of noncompliance? Yes No

Comments: _____

Signature _____ Title _____

Please attach a copy of the following documents:

Transfer Policy

Board Order, if applicable

Monitoring Agreement and/or Amendments