LOUISIANA STATE BOARD OF PRACTICAL NURSE EXAMINERS
131 AIRLINE DRIVE, SUITE 301
METAIRIE, LOUISIANA 70001-6266
(504) 838-5791
FAX (504) 838-5279
www.lsbpne.com

MEDICATION(S) FORM

(To be completed and mailed by practitioner)
THIS FORM WILL NOT BE ACCEPTED BY FASCIMILE

Please complete this form and mail it to the board office within ten (10) days of prescribing the medication(s). The completed form **must be mailed by the practitioner only**. If you have any questions, please contact the compliance department at (504) 838-5791.

Name of individual: _____ **D.O.B.** ____/____/____

By my signature below, I hereby verify that the individual has presented me with a copy of his/her board order/consent order, including all findings of fact and conclusions of law. I am aware that he/she is required to submit to random drug screens. **The use of narcotics or controlled substances should be avoided when alternative treatments are available.**

PRESCRIPTION INFORMATION

Date of RX	Name of medication	Quantity, dosage and number of refills*	Reason for medication/diagnosis	Controlled/mood altering/addictive or has abuse potential? YES	NO	Could the medication being prescribed negatively impact his/her duties as an LPN? YES	NO

***NOTE: If refills are prescribed, this form must be updated every six months.**

_____
Prescriber name (Please print)

_____
E-mail address

_____
Prescriber's area code/phone number

_____
Prescriber's signature **Date**