Arkansas Department of Health

Arkansas State Board of Nursing
1123 S. University Ave., #800 • Little Rock, AR 72204
(501) 686-2700 • Fax (501) 686-2714

TREATMENT PROVIDER REPORT

Licensee_____ License number_____

Due Dates _____
Monitored nurse to fill in the **months** the reports are due. All documentation must be submitted by the 10th of the months listed.

Licensee is required to submit a Treatment Provider Report every three (3) months. Please complete and give to licensee to submit or you may send directly to the Board at ASBN.monitoring@arkansas.gov.

Primary Treatment Focus_____

Secondary Treatment Focus_____

Medication	Indication	Dosage & Frequency	Number of Refills

Please use the back of this form if you need additional space to list medications.

Participant's current diagnosis_____

Has there been any change in participant's diagnosis? If yes, please explain_____

_____

Participant's treatment plan, recommendations, and interventions_____

_____

_____

_____ _____
Treatment Provider signature Print name and title

_____ _____
Date Phone number

Instructions for Licensee if report given to you by provider:

- Licensee **with Affinity** drug monitoring account – upload signed document in your Affinity account under Documentation/Reports/Available Reports/Add Attachment
- Licensee without drug monitoring – please email to ASBN.monitoring@arkansas.gov.