



New Jersey Office of the Attorney General

Division of Consumer Affairs
New Jersey Board of Nursing
124 Halsey Street, 6th Floor, P.O. Box 45010
Newark, New Jersey 07101
(973) 504-6430

**Reporting Form
For Drug Diversion and Impairment**

(Please print clearly.)

Please be advised that any information you supply on this complaint form may be subject to public disclosure. If an investigation into the matter is conducted, the information is subject to public disclosure only after the completion of the investigation. You are also advised that the completed reporting form is a "government record," which the Board may be obligated to provide to anyone making a request pursuant to the Open Public Records Act (OPRA).

You are further advised that pursuant to Section 4B of Executive Order No. 26, information concerning any individual's medical, psychiatric or psychological history, diagnosis, treatment or evaluation is **not** a government record subject to public access.

This case may be assigned to the Enforcement Bureau within the Division of Consumer Affairs. If this is the case, please be aware that you may be contacted for follow-up investigative activity. The Board of Nursing must be advised of any new information that develops once a case is reported.

<i>Facility Information</i>	<i>Complaint Reported Against</i>
Name of Facility: _____ Name and Title of Person Reporting: _____ _____ City: _____ State: _____ ZIP code: _____ Telephone Number: _____ <small>(include area code)</small> Fax Number: _____ <small>(include area code)</small> E-Mail Address: _____ Was the C.D.S. Theft - Loss Report made to the Drug Control Unit? <input type="checkbox"/> Yes <input type="checkbox"/> No Were the local police notified? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," which police station? _____ Who is the police contact person? _____ _____ Date of Report: _____	Name: _____ Current Employment Status: Suspended: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <small>(Reason)</small> _____ Terminated: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <small>(Reason)</small> _____ Referred to RAMP: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ <small>(Reason)</small> _____ Is the employee aware of the facility's investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No Home Address: _____ City: _____ State: _____ ZIP code: _____ Telephone Number: _____ <small>(include area code)</small> Title: _____ License Number (if known): _____ Licensed by another state's Board of Nursing: _____ Licensed by another N.J. professional board: _____ Date of Report: _____

1. For C.D.S. loss, theft or suspected or documented diversion, please describe the facts of your complaint regarding the substance abuse/impairment issue being reported addressing each of the following:
 - a) The nature of the complaint
 - b) The type and amount of medication lost or diverted and approximately when this activity occurred,
 - c) The type of dispensing system in place - manual or automatic,
 - d) The nursing personnel potentially associated with this complaint, and why,
 - e) The results of facility review, including testimony of patients and staff regarding the suspect's behavior and nursing practice including documentation of assessment of need for C.D.S., its administration, and documentation of administration,
 - f) The existence of any reports or memoranda of investigation prepared regarding this matter, and
 - g) The agencies notified (e.g. the Board of Nursing, A.T.D. Committee, others).

2. Was the person suspected of diversion or substance abuse confronted? If the answer to this question is "yes," by whom? Did the person admit to the allegations of diversion or substance abuse? Please provide a fax copy of any written statement of admission by the nurse, the incident report or an affidavit.

3. Did the person who admitted to diversion or substance abuse make contact with RAMP?

4. Please attach scanned copies of all materials that support your suspicion or allegation of substance abuse to this e-report form. If your facility does not have scanning capabilities, please forward a copy of the support materials to the mailing address below, to the attention of Deborah Zuccarelli, BSN, RN, Alternative to Discipline Supervisor.

5. I certify that the statements made by me in this complaint are true and any documents attached electronically or mailed to the Board of Nursing office are true copies. I am aware that if any of the statements made by me are willfully false, I am subject to punishment.

Signature of Person Reporting*

Date

* The person who has completed the form must sign this certification, electronically if possible. Supporting documentation (scanned PDF files) may be e-mailed to Ramp@dca.lps.state.nj.us or hard copies may be mailed to the following address:

State of New Jersey
New Jersey Board of Nursing
Attention: Deborah Zuccarelli, BSN, RN
Alternative to Discipline Supervisor
P.O. Box 45010
Newark, New Jersey 07101