IPRP RECOVERY MONITORING AGREEMENT (RMA) NURSES

This **RMA** is entered into this _____day of _____, _____, by and between the Indiana Professional's Recovery Program (IPRP), Administrator of the Indiana State Nurses Assistance Program (for nursing) and:

_____

(Name of Participating Nurse as it appears on Nursing License)

☐ **REGULATORY RMA** ☐ **NON-REGULATORY RMA**

1. **INDIANA PROFESSIONALS RECOVERY PROGRAM (IPRP)** is a program approved by the Indiana State Board of Nursing (ISBN) and is administered by Parkdale Aftercare on behalf of the Indiana Professional Licensing Agency (IPLA). IPRP is designed to monitor nurses who have been affected by the use/abuse/dependency from alcohol and/or other addictive drugs or substances. The program permits such nurses (LPN, RN, NP, FNP, APRN, CRNA) to safely practice their profession while recovering from substance use/abuse/dependency. IPRP's approach is to provide a monitoring program with a confidential and therapeutic approach to facilitate rehabilitation and recovery.

2. The Participant is either voluntarily entering the program or has been identified by the Office of the Indiana Attorney General (OAG) or ISBN as a nurse affected by a substance use/abuse/dependency and is in need of rehabilitation under the IPRP monitoring program. The Participant acknowledges receipt of the **IPRP Participant Handbook** (which is incorporated in this Agreement by reference) and confirms all such provisions of this RMA have been read and understood or that legal counsel has been consulted to explain the meaning of the language. Further, the Participant, by initialing the provisions below, agrees to be bound by the terms and conditions of this Agreement, as well as the requirements and provisions contained in the IPRP Participant Handbook.

In consideration of the mutual benefits contained herein, the parties agree as follows:

A. Initials: _____***BINDING EFFECTS OF TERMS AND CONDITIONS:***
By signing this RMA and entering the program, I agree to follow and be bound by the terms and conditions of this Agreement. I further agree that any exceptions or modifications to the terms of participation must be approved, in writing, by a member of the IPRP staff.

B. Initials: _____***RECEIPT OF PARTICIPANT HANDBOOK:***
I acknowledge receipt of the Participant Handbook and agree to follow and be bound by the terms and conditions contained in such Handbook as well as the provisions of this Agreement. **I also acknowledge that I have been provided an information sheet on 'Missed Check-Ins,' as well as a letter from the medical review officer on 'How to avoid abnormal and/or dilute urine.'**

C. Initials: _____***MEDICATION USE:***

I understand that ISNAP will not refuse to enroll, limit the participation of, penalize, or otherwise discriminate against individuals with disabilities, including individuals with OUD, because such individuals use medications prescribed by a licensed practitioner as part of a medically necessary treatment plan.

I understand I must refrain from eating or drinking any products containing alcohol, as well as, any over-the-counter medication containing any amount or kind of alcohol, ephedrine or diphenhydramine, certain herbal compounds, THC, or any other products that may cause me to produce a positive Urine Drug Screen to remain in compliance with IPRP. In addition, all forms of CBD Oil are prohibited even if the label states the product is "THC Free." Kombucha Tea, Kratom, Whippets, Delta 8 and Delta 10 cartridges, poppy seeds, hand sanitizer, mouth wash nor the use of Vanilla Extract will be accepted as an excuse for a positive urine drug screen.

If I am hospitalized or otherwise require any medical or dental treatment resulting in the prescribing of any mood-altering medication, I will immediately report this event to IPRP and my treatment provider(s). I will immediately send supporting documentation (i.e., discharge summary and/or prescriptions) to my IPRP Clinical Case Manager within 3 days/72 hours. I will upload any prescriptions I am taking into my Spectrum 360 app under the prescription tab. Further, I understand I may be removed from work if it is determined the positive test result is not due to ingestion of documented prescription medication and I must have a negative drug screen result before I may be allowed to return to work.

I further understand and acknowledge the ingestion of some food or food supplements (i.e., herbs, poppy seeds) and over-the-counter medications (i.e., cough syrup, mouth wash, cold remedies) may result in a positive test. As such, **no claim shall be made and IPRP will accept no claim that the presence of drugs in my specimen resulted from said items.** A positive UDS may invoke consequences, including but not limited to, re-assessment by treatment provider, increased UDS frequency, an extension of my RMA, required attendance at a relapse-prevention group, dismissal from the program, or other requirements.

D. Initials: _____***INSPECT REPORTS:***

Participant hereby authorizes IPRP to access any and all of participants' information through the Indiana Prescription Monitoring Program. This information obtained through an INSPECT report may be used to confirm written or verbal attestations made by participants related to his/her use of prescription drug usage and to ensure accurate reporting of participants' status to the applicable licensing board. The INSPECT reports may be obtained by a prescriber delegate at the request of and supervision of a registered prescriber. This information will still be subject to all applicable state and federal safeguards regarding the sharing of the information.

Please LIST any prescription medications, over the counter medications, CBD oils, or other natural products you are currently taking (include dosage) below. Please include whether the substance is prescribed by a medical professional, and if so, by whom:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

E. Initials: _____ ***URINE DRUG SCREENS:***

Initially the UDS Frequency is _____ per year. I understand my frequency could vary as a result of change in employment status, relapse, etc. **Further, I understand that I may be subject to PETH, hair, nail, and/or breathalyzer.**

I understand that if I am required to be breathalyzed, I will have to utilize the SoberLink breathalyzer (at my cost) _____ times per day, for up to 1 year, or at the discretion of my case manager. I understand that I may be subject to further testing such as UDS and or quarterly PETH testing, and I understand that these tests are an additional cost.

Please be aware prices are approximations and may change and/or vary by location and third party vendors. A urine drug screen costs approximately $52. A Peth test costs approximately $133. Hair and/or nail tests vary from $91 to $406 depending on the panel used. The SoberLink breathalyzer costs approximately $4.00 per day, $299 with a 365-day commitment or $349 with a 120-day commitment. Please be aware these prices do not include site fees which vary from location to location. Site fees may vary from $10 to $50. ISNAP (IPRP) does not set the pricing for drug screens as these are handled by a third party vendor. *Please be aware prices may change without notice and observed collections may be an additional cost.

As part of my monitoring requirements, I am required to participate in random urine drug screens through Affinity eSolutions, Inc (SPECTRUM). Affinity Online Solutions (AOS)'s contact information is:

Affinity eSolutions, Inc., 100 Allstate Parkway, Suite 303, Markham, Ontario L3R 6H3.

The daily call-in phone number is: 877-267-4304; I understand I may also go online to check in at www.affinityehealth.com. I agree to utilize collection sites approved by Affinity to ensure all specimens are monitored with the chain of custody (COC), temperature, and pH/specific gravity controls required by IPRP. I understand I must call daily (Monday–Sunday), between 5am–5pm, EST, including holidays. I understand if I am directed to provide a urine sample on a weekend day or holiday that I need to use one of the 24 hour sites from Affinity's list of approved sites.

Initials: _____ **I understand upon activation of my Spectrum Compliance App, I will need to fund my account in the amount of $75.00.**

I understand IPRP will require some UDS specimens to be observed at collection. An observed collection will be indicated when I call or check in for my daily instructions from Affinity. It is recommended I always maintain a minimum of $75 on my account.

I understand I may have a positive test re-analyzed at another qualified laboratory for an additional charge. **I also understand I am responsible for the costs associated with the drug screens. I understand SPECTRUM will assign a unique PIN number and provide instructions to me.**

F. Initials: _____ ***TREATMENT PROVIDERS:***

As required by IPRP, I agree to undergo a complete medical, psychiatric and/or substance abuse evaluation at an IPRP approved treatment provider, and/or to provide information regarding the evaluations and treatment plans, including medication used to treat opioid use disorder or other disabilities, by my current treatment providers. If treatment is recommended, I agree to follow all treatment recommendations to the extent that they do not conflict. I also understand and agree that any and all costs related to treatment (Residential, PHP, IOP, aftercare, and individual therapy) are solely my responsibility. I agree to the following:

Facility Name: _____

Facility Address: _____

Contact Person: _____

Phone Number: _____

Level of Treatment: _____

I will ensure that **my treatment provider(s) will submit weekly updates [Inpatient only] and quarterly reports** while in treatment, as well as a final discharge summary. **If applicable, the quarterly reports must include copies of drug screen results demonstrating compliance with any oral Naltrexone prescriptions or Vivitrol injections.**

If an **Addiction Physician** (physician certified in addiction medicine) is recommended, I agree to see:

Physician Name: _____

Phone Number: _____

Facility Name: _____

Facility Address: _____

_____ I will ensure **my Addiction Physician will submit quarterly reports** as well as a final discharge summary.

If a **Psychiatrist** is recommended, I agree to see:

Psychiatrist Name: _____

Phone Number: _____

Facility Name: _____

Facility Address: _____

_____ I will ensure **my Psychiatrist will submit quarterly reports** as well as a final discharge summary.

If **Individual Counseling** is recommended, I agree to see:

Counselor Name: _____

Phone Number: _____

Facility Name: _____

Facility Address: _____

_____ I will ensure **my Individual Counselor will submit quarterly reports** as well as a final discharge summary.

If any treatment provider(s) or physician(s) determine I am not chemically free from any prohibited substances, have been non-compliant with the RMA or that I am unable, for any reason, to practice nursing safely, they will immediately notify IPRP and appropriate steps will be taken. I understand that the consequences for failure to comply with treatment plans/recommendations may result in action being taken against my file including but not limited to unsuccessful discharge from the program, being reported to the Indiana State Board of Nursing and/or the Indiana Office of the Attorney General.

G. Initials: _____ ***TWELVE STEP SUPPORT:***

I understand that participation in 12-Step and/or Nurse Support (Caduceus) meetings may be required.

I agree to verify completion of monthly self-help meeting logs by the 10th of each month for the previous month through Affinity Online Systems.

I am required to attend _____ meetings per week. My meeting attendance can include any combination of Nurse Support Group, NA or AA meetings. I understand I am able to attend Celebrate Recovery, Smart Recovery or other support meetings as approved by IPRP. I will submit all meetings through the Affinity / Spectrum Online Systems on an ongoing and monthly basis and I will log all my meeting attendance into the calendar on my Spectrum Compliance App and submit reports at the end of each month. Please contact Affinity Spectrum Help Desk for assistance with input of self-help meetings on your calendar and submission of monthly meeting logs at the end of each month. The Affinity Spectrum Help Desk can be reached at 877.267.4304.

In addition, I will obtain a sponsor within 60 days of signing my RMA and I will notify IPRP when I have obtained my sponsor. My sponsor will submit quarterly reports and I authorize IPRP to contact my sponsor, with an appropriate release, if they have concerns about my recovery program.

Sponsor's First Name and Last Initial: _____

Phone Number: _____

H. Initials:_____ ***EMPLOYMENT:***

My return-to-work date is: _____

***Licensee will require a return-to-work assessment.** ☐ **Yes** ☐ **No**

I agree to get prior approval from IPRP before returning to work or accepting/changing my employment. To assure workplace safety, I agree to have an identified worksite monitor in any place of employment that involves my nursing license or is a healthcare setting. As a requirement of this RMA I may have, including but not limited to, access to controlled substances, worksite monitor/supervision, the type of work setting/unit, hours of practice and availability for on-call. I will notify IPRP of any changes in my employment (i.e., probation, suspension, termination, or my resignation). I will contact my Clinical Case Manager and ask for the Change of Employment Form, fill it out in its entirety and return it to my Clinical Case Manager **prior to the start of employment. Also, I understand that I may not take any prohibited mood-altering substance, within 48 hours of my work shift.**

If this is a regulatory RMA, you must present a copy of the Findings of Fact, Conclusions of Law, And Order from the Indiana State Board of Nursing to your work site monitor for his/her signature. A copy of the signed Order MUST be sent to the Indiana State Board of Nursing. Further, you must provide a copy of this RMA to your employer/worksite monitor/EAP and have whomever your employer deems responsible sign the RMA and return the signed copy to your clinical case manager.

I _____ **have access to controlled substances through my employer.**

I understand that I will be removed from work immediately if I have an unexplained, positive, adulterated, or abnormal urine drug screen.

I understand that I will need to actively work as a nurse for at least 12 months prior to the end date of this monitoring agreement in order to successfully complete IPRP.

(If currently employed), I am authorized to work at:

_____

Name of Employer: _____

Address: _____

City, State, Zip: _____

Worksite Monitor: _____

Phone Number: _____

Email: _____

I am limited to _____ hours per day or _____ hours per week, during the hours of _____.

I. **NARCOTICS RESTRICTION**

I understand I have a narcotics restriction for _____. Further, I understand the narcotics restriction requirement must be met at the same employer for the entirety of the narcotic restriction.

Signature: _____

The _____ narcotics restriction begins when I am actively employed as a healthcare provider in a health care setting.

To have my narcotics restriction lifted, I must submit supporting documentation from my sponsor, work site monitor, therapist, etc. Further, I also need to be in a compliance with the requirements of my RMA. I understand my narcotics restriction will not be lifted until my clinical case manager has sent me written approval.

J. Initials: _____ ***QUARTERLY SELF-REPORTS***

I agree to submit Quarterly self-reports **by the 10th of the month** for the previous 3 months through Affinity/Spectrum Online Systems. In addition, I will ensure that any identified treating therapist(s), Addiction Physician, worksite monitor, and/or sponsor in this RMA will submit **quarterly reports**. I understand it is my responsibility to ensure all reports are submitted on time.

K. Initials: _____***MONITORING INTERRUPTION***

When submitting a monitoring interruption, I will submit the interruption as soon as possible to inform my clinical case manager of the location I am traveling to or documentation for the medical necessity for a monitoring interruption. This will be completed prior to any travel or medical issues that are not emergent.

I understand if I am traveling for vacation, business, or any other reason, I will include information related to the destination under the monitoring interruption request tab on my Affinity Spectrum app. I understand that it is my responsibility to have a selection site near my destination if I am selected to test. I understand that in some circumstances, I may be selected for further testing (PEthStat, Hairstat, Nailstat, ect.) when I return home if I am going out of the country or traveling within the United States when a site is not within a reasonable distance of where I will be staying. I also understand that I am required to check-in during the time of my monitoring interruptions and that missing a check-in will constitute non-compliance during a monitoring interruption. **By initialing this section, I have read and understand the monitoring interruption sheet provided to me by my clinical case manager in my RMA packet.**

L. Initials: _____***AUTHORIZATION FOR RELEASE OF INFORMATION:***

I understand I will be required to sign a release of information (ROI) form authorizing IPRP to exchange information with others involved in my monitoring, as deemed appropriate by IPRP. I understand IPRP is required by law to notify the Office of the Indiana Attorney General (OAG) and the Indiana State Board of Nursing (ISBN) of any circumstances indicating that I may be a threat to the public safety or welfare. Other releases which may be obtained are from treating physicians, therapists and others involved in my care, pharmacies, worksite monitors, family members and others as needed to coordinate my monitoring. There is no time limit specified in the release. If I have voluntarily entered IPRP (confidential/non-regulatory) and am anonymous to the OAG or the ISBN; I will remain anonymous as long as I am compliant with IPRP requirements. If I elect not to participate, withdraw without notice, or am dismissed from IPRP for non-compliance, I understand that I may be reported immediately to the OAG or the ISBN for further review and possible action.

If I have had action taken against my license or have been reported by the OAG's office, or if I elect not to participate or am dismissed for non-compliance, IPRP will immediately file an Order to Show Cause (OTSC) the OAG and/or ISBN for further review.

M. Initials: _____***MODIFICATIONS:***

I understand and agree IPRP may modify the terms of this agreement as necessary to protect public safety or to more effectively facilitate my progress in recovery. All modifications will be reflected in an addendum to this RMA signed by me and IPRP. My failure to agree to and/or comply with modifications may be considered a breach of this agreement and result in this RMA being extended or terminated. **I also understand that any requests I make for modifications must be made in writing with accompanying letters of support and approved by IPRP if I am in compliance and have maintained compliance with my RMA.**

I further understand I may request, in writing, a meeting with a representative of IPRP at the request of either party to review my compliance with the terms of this RMA. I agree to notify IPRP promptly of any changes in my address, telephone numbers, etc., and to provide copies of this RMA when any changes are made with my worksite monitor, treatment providers, addiction physician, etc. I further understand IPRP is an Indiana based program and, if I leave Indiana and wish to retain my nursing license, my RMA will be transferred to the monitoring agency of that State.

N. Initials: _____ ***VIOLENCE:***

I understand any threats of harm or acts of violence to IPRP, or its employees will result in immediate case closure, reported to the OAG, ISBN, as well as to law enforcement.

O. Initials: _____ ***COSTS:***

I accept responsibility for payment of all costs incurred while I am a participant in IPRP. I understand that if I am noncompliant with this agreement and am terminated or otherwise released from the program and seek to re-enter the IPRP program, a fee of $250 will be assessed before re-entry may be allowed. I will be responsible for the monthly participant fee currently paid for by the State if my nursing license lapses or has an expired status. The monthly fee for nursing students is $50 and the monthly fee for nurses is $150. An additional fee may also be assessed if the length of the RMA is extended, and the fee will be $150. I understand and agree that I will have 14 days to pay these fees.

P. Initials: _____ ***LIABILITIES:***

I understand and agree IPRP and Parkdale Aftercare, or their respective employees, agents, volunteers, or members of the Board of Directors, will not be liable nor held responsible for any relapse(s) which I may experience and/or the consequences related to the use/abuse/dependency of any substances. I further agree to hold harmless the above entities from any litigation costs (including reasonable attorney fees) incurred by them as a result of any actions at law, or in equity, filed by me or any third party, based upon my use/abuse/dependency of any substances or in the administration of the ISNAP program.

Q. Initials: _____ ***DISCLOSURES:***

I understand and agree IPRP shall provide information and records of my participation and recovery status to authorized program staff and individuals for whom a ROI has been signed as required by Indiana Code IC 25-23-1-31. Additionally, I agree to hold harmless IPRP, Parkdale Aftercare LLC, or their respective employees, agents, volunteers, or members of the Board of Directors, from any good faith disclosures made by them to any third party relating to my use/abuse/dependency addiction to any substance or the status of my recovery there from.

R. Initials: _____ ***PRACTICE BY RECOVERING NURSE:***

I agree to comply with all applicable standards, rules, and statutes governing or regulating the practice of nursing in the State of Indiana. I do understand that my participation in the monitoring program does not preclude the AG's Office nor the ISBN from taking disciplinary action against me based on a formal complaint, report, or other proceedings that may be filed against me.

S. Initials: _____ ***TERMS FOR MAINTENANCE OF RECORDS AND INFORMATION:***

I understand and agree, pursuant to Indiana Code IC 16-39 *et seq*., IPRP shall maintain all information and records relating to my participation in the RMA for a period of seven (7) years following the date of my completion of the monitoring program. I further understand that following the seven (7) year period, all such records pertaining to my participation shall be deleted from computer files and hard copies will be destroyed.

T. Initials: _____ ***HEADINGS OF PARAGRAPHS:***

I understand and agree that the headings of the paragraphs do not control the contents thereof but rather the terms and conditions of this RMA as a whole shall control its application.

U. Initials: _____ ***CONSEQUENCES FOR FAILURE TO COMPLY:***

I understand that failure to comply with program requirements, treatment plan, or other terms of my RMA may result in the following:

IC 25-23-1-31 section (g) The board designated rehabilitation program (ISNAP) shall:

(1) immediately report to the board the name and results of any contact or investigation concerning an impaired registered nurse or licensed practical nurse who the program believes constitutes a certain, immediate, and impending danger to either the public or the impaired registered nurse or licensed practical nurse; and

(2) in a timely fashion report to the board an impaired registered nurse or licensed practical nurse:

(A) who refuses to cooperate with the program;
(B) who refuses to submit to treatment; or
(C) whose impairment is not substantially or significantly alleviated through treatment, as determined by accepted medical standards.

Also, under Title 848 Indiana State Board of Nursing section 6 [848 IAC 7-1-6(e)] ISNAP:

(1) shall report to the board the name and license number of a nurse that has failed to comply with the provisions of the rehabilitation and monitoring program and the circumstances surrounding the failure to comply;

(2) may release information to the board or to the consumer protection division of the office of the attorney general in compliance with: (A) IC 25-23-1-31; and (B) all applicable state and federal confidentiality laws and regulations.

V. Initials: _____ ***LENGTH OF RMA:***

This RMA will remain in effect for a minimum of _____years (or _____months) from the creation date.
That date is _____. Therefore, assuming continued active involvement in recovery, and compliance with all requirements of the IPRP, this RMA will end on _____.
In the eventuality of relapse or non-compliance, this RMA may be extended or terminated.

W. **Signatures**

Clinical Case Manager Signature: _____ Date: _____

Clinical Case Manager Print: _____

Program Participant Signature: _____ Date: _____

Employer Signature: _____ Date: _____