

PARTICIPANT GENERAL INFORMATION

Instructions: Please complete entire form (print)

First name: _____ Last Name: _____

Other names used: _____

Street address: _____

City/State/Zip: _____ County: _____

Region: East TN Middle West

Social Security No. _____ Date of Birth: _____

Gender: Female Male Ethnicity (optional): _____

Marital Status: Married Divorced Single

Telephone number (where you can be contacted during business hours): _____

Telephone (Home) _____ Mobile: _____

Profession (select only one):

- RN CRNA NP LPN PA PT PTA OT OTA Respiratory
 EMT EMT-P Medical Laboratory

TN license #: _____

Have you ever been licensed in another state? Yes No

If yes, provide state(s) _____ License number _____

Education: Diploma LPN Associate Degree Bachelors Degree

Student Certificate Masters Degree Doctorate Other _____

List school where you graduate from healthcare training:

_____ State: _____

Emergency contact: _____

Relationship: _____ Day Phone: _____

Date of first contact with TnPAP: _____

To your knowledge, have you been reported to TN Department of Health? Yes No



How were you referred to TnPAP?

- An employer(s), supervisor, EAP, or other work related party referred me.
- A spouse, significant other, friend, coworker, family member, or other outside acquaintance referred me.
- The licensure board, a screen panel, board committee, or board staff referred me.
- I called TnPAP myself. No one else knew of my problem(s).
- TN licensure board (disciplinary action).
- I don't know.

Have you been in the TnPAP before? Yes No How many times? 1 2 3

Have you been in a peer assistance program in another state? Yes No

If yes, what state? _____ When? _____

Work setting (at time of report) Agency Hospital Long-Term Care

MD office/Clinic/Ambulatory School

Other, specify _____

Specialty (at time of reporting): Administration Anesthesia Chemical Dependency

Education Emergency Gerontology Home Health Oncology

ICU/CCU/Step-Down Med-Surg OB/GYN OR/PAR

Peds Psych Public Health Urology Non-clinical

None Other, specify _____

Position (at time of reporting): Administrative/Executive Faculty Supervisor

Office/Clinic Staff Nurse Charge Nurse Educator/QA/UR Manager

Float Traveler Other, specify _____

Employer (at time of incident and/or report) _____

Address: _____

City/State/Zip: _____

Phone No. _____ County _____

Years of experience in my licensed profession: _____



Treatment types: Basic Outpatient (<5 hours/week) Intensive Outpatient (5-20 hours/week)

Day Treatment (20+ hours/week) Long-term residential

Impaired Professionals Program Other, specify _____

Admission Date	Facility	Treatment for (Diagnosis)	Type/Length of Treatment	Discharge Date

Family History of Alcoholism/Addiction: Parent Grandparent Sibling

Aunt/Uncle Unknown None Other, specify _____

Chemical History – Check preferred chemicals in each category

Chemical	Age 1 st used	Preferred Route	Largest Amount Used	Frequency	Date last used
Alcohol (Ethanol)					
Amphetamines					
Anesthetics <input type="checkbox"/> Fentanyl <input type="checkbox"/> Sufentanyl					
Benzodiazepines <input type="checkbox"/> Valium (Diazepam) <input type="checkbox"/> Librium (Chlordiazepoxide) <input type="checkbox"/> Ativan (Lorazepam) <input type="checkbox"/> Xanax					
Butabarbital					
Butalbital (Florinal)					
Butorphanol (Stadol)					
Clonazepam (Klonopin)					
Clorazepate (Tranxene)					
Cocaine					
Cocaine Metabolite					
Designer drugs, specify _____					
Droperidol					
Floreszepam					
Halcion (Triazolam)					
Hallucinogens, specify _____					
Hydrocodone <input type="checkbox"/> Vicodine <input type="checkbox"/> Lortab <input type="checkbox"/> Lorcet					
Hydromorphone					



Marijuana or THC					
Mepergan (Meprozone)					
Methadone					
Methamphetamines					
Nordiazepam					
Norpropoxphen					
Opiates					
<input type="checkbox"/> Demerol					
<input type="checkbox"/> Morphine					
<input type="checkbox"/> Dilaudid (Meperidine)					
<input type="checkbox"/> Heroin					
Other, specify					
Oxazepam (Serax)					
Oxycodone					
<input type="checkbox"/> Percodan					
<input type="checkbox"/> Percocet					
<input type="checkbox"/> Tylox					
<input type="checkbox"/> Pentobarbital					
<input type="checkbox"/> Roxicet					
<input type="checkbox"/> Roxicodone					
Phenobarbital (Solfoton)					
Ritalin					
Secobarbital					
Sedatives, Hypnotics, Barbiturates					
Temazepam (Restori)					
Ultram (Tramadol)					
Versed (Midazolam)					

From the above list, what is your drug-of-choice?

1. _____
2. _____
3. _____
4. _____



