Tennessee Professional Assistance Program
545 Mainstream Drive, Suite 414
Nashville, TN 37228

www.tnpap.org
Phone: 615-726-4001
Fax: 615-726-4003

VERIFICATION OF PRESCRIBED MEDICATION

PRINT ALL INFORMATION

Instructions: Participant, fill in your name, your phone number and information for your TnPAP case manager. Any individual who is prescribing medication for you must complete a form and send to TnPAP. **The completed form will be accepted only if provided to TnPAP by practitioner's office.**

TnPAP Participant's Name SSN Phone Number

TnPAP Case Manager's Name Phone Number

The individual who is providing this form is a participant in the Tennessee Professional Assistance Program (*a monitoring program for his/her licensure board*). As part of the program, the individual is to provide documentation of all prescribed medications.

Please take a few minutes to complete the form below regardless of method use (e.g., administered in office, sample(s) given, prescription given or prescription called to pharmacy). After completing the form, please fax it to the TnPAP office at 615-726-4003. If you have any questions, please call TnPAP at the following telephone number: 615-726-4001.

PRESCRIPTION INFORMATION

Prescription Date	Type of Medication	Dispense Quantity	Dosage	Refills	Frequency

Reason for Medication:

☐ Medical related
☐ Dental related
☐ Psychotropic
☐ Pain management – short term
☐ Pain management – long term

I acknowledge that my patient has informed me that (s)he is (select one):

☐ Recovering from chemical dependency, and the use of mood-altering drug(s) may trigger a relapse; or
☐ Being monitored and has agreed to refrain from mood-altering drugs; or
☐ **NOT** being monitored as a result of substance abuse/addiction; however, must still submit a list of all medications that are administered as part of the monitoring agreement.

Practitioner's Name (Please Print) Practitioner's Signature

Address City, State, Zip

Office Telephone Number Date