

WEST VIRGINIA STATE BOARD OF EXAMINERS FOR
LICENSED PRACTICAL NURSES

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CHARLESTON, WEST VIRGINIA 25311-1688

PHYSICIAN/PSYCHOLOGIST/DRUG COUNSELOR REPORT

LICENSEE NAME _____ **DUE DATE** _____

THIS FORM MUST BE HANDWRITTEN
and submitted directly to the WV Board of Examiners for LPN

Recommended frequency of appointments: _____

List appointment dates: _____, _____, _____, _____, _____, _____, _____

Has the client kept all appointments Yes ___ No ___. If no explain: _____

PROGRESS AND ASSESSMENT OF CURRENT MENTAL CONDITION: _____

It is my opinion that the above named client does not currently have a mental or physical disability which renders him/her unable to practice nursing with reasonable skill and safety: AGREE _____ DISAGREE _____

If DISAGREE, please explain:

Document any evidence of substance abuse:

Signature Title Date

Name (Typed or Printed) Facility/Agency

Address:

Telephone Number: License No. _____