BP-A1019
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INMATE NICOTINE REPLACEMENT THERAPY APPROVAL

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

INMATE NAME: _____ DATE: _____

INMATE REG. NO. _____ INSTITUTION: _____

____ **Six (6) Week NRT Dosage Program** **Expiration date:** _____

21 mg Patches (2 WEEK SUPPLY) Purchased on _____ (initialed by Commissary)

14 mg Patches (2 WEEK SUPPLY) Purchased on _____

7 mg Patches (2 WEEK SUPPLY) Purchased on _____

_____ **Ten (10) Week NRT Dosage Program** **Expiration date:** _____

21 mg Patches (2 WEEK SUPPLY) Purchased on _____ (initialed by Commissary)

21 mg Patches (2 WEEK SUPPLY) Purchased on _____

21 mg Patches (2 WEEK SUPPLY) Purchased on _____

14 mg Patches (2 WEEK SUPPLY) Purchased on _____

7 mg Patches (2 WEEK SUPPLY) Purchased on _____

Health Services Provider Signature _____

Health Services Provider Name Stamp _____

When a purchase is made on this authorization, the Commissary staff member shall initial the **Purchased on** line.

This authorization is to be returned to Health Services by the Commissary when the inmate has made the last authorized purchase.

Three (3) month smoking status: ____ smoking ____ non-smoking

Six (6) month smoking status: ____ smoking ____ non-smoking

Smoking Cessation Program completed on: _____