The attached are Primary Source Documents of the Idaho Board of Nursing for:

Monica Nilsson

Idaho Board of Nursing – PO Box 83720 – Boise, Idaho 83720-0061 – (208) 334-3110
BEFORE THE IDAHO STATE BOARD OF NURSING

In the Matter of the License of: )  
MONICA NILSSON, ) Case No. BON 05-075  
License No. N-34570, ) FINDINGS OF FACT,  
) CONCLUSIONS OF LAW AND  
Respondent. ) FINAL ORDER 

Having reviewed the documents appended hereto, the Idaho State Board of Nursing (the "Board") enters the following Findings of Fact, Conclusions of Law, and Order:

FINDINGS OF FACT

1. Monica Nilsson ("Respondent") has been licensed by the Idaho State Board of Nursing under License No. N-34570 to engage in the practice of nursing in the State of Idaho.

2. On or about August 3, 2005, the Board received a Report of Violation of the Nurse Practice Act from Respondent’s employer, Barbara Daugharty, M.D. The report indicated that Respondent was observed gaining access to the locked narcotics drawer in Dr. Daugharty’s office on several occasions. When a bottle of hydrocodone elixir was discovered missing, Respondent was confronted and asked to undergo drug screening. Respondent informed Dr. Daugharty that she would test positive and that she had previously undergone treatment. Respondent also admitted to taking Lor-tab from the drawer and to taking it at work. Respondent was then terminated from employment with Dr. Daugharty.

3. On September 6, 2005, Respondent voluntarily surrendered her license and agreed to enter treatment. A true and correct copy of Respondent’s Voluntary Surrender of License is attached hereto as Exhibit A.

4. On October 20, 2005, Respondent signed a Nurse Monitoring Contract with the PRN, a true and correct copy of which is attached hereto as Exhibit B.

5. On March 6, 2006, Respondent sent a letter to the Board advising that she
was withdrawing from the PRN, a true and correct copy of which is attached hereto as Exhibit C.

CONCLUSIONS OF LAW

1. As a licensed nurse in the State of Idaho, Respondent is subject to the jurisdiction of the Board and to the provisions of title 54, chapter 14, Idaho Code.
2. Respondent’s Idaho License No. N-34570 is conditioned upon her complying with the laws and rules of the Idaho State Board of Nursing.
3. Respondent diverted drugs from her employer without prior consent or authorization from her employer.
4. Respondent possessed and took prescription drugs while at work which had not been prescribed to her.
5. Respondent voluntarily surrendered her license and agreed to enroll in and comply with the terms of the PRN. She has failed to do so and has withdrawn from the program.
6. Respondent’s acts as set forth above constitute violations of the laws and rules governing the practice of nursing in the State of Idaho; specifically, Idaho Code §§ 54-1413(1)(e) and (g) and Board Rules (IDAPA 23.01.01) 100.06, 100.08, 100.09.a, 101.01, 101.03.e, 101.04.e and 101.05.f.
7. Pursuant to Idaho Code § 54-1413(3)(a), the Board is authorized to impose sanctions against Respondent.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law, and good cause being shown, it is hereby ordered that:

1. License No. N-34570 issued to Monica Nilsson is:

   [X] Revoked
   _______ Suspended _______ days/year(s) ______ indefinitely

2. At such time as Respondent requests reinstatement of licensure, she shall comply with the requirements of Idaho Code § 54-1411(3) and IDAPA 23.01.01.120.

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER - 2
This will include, but is not limited to, providing the following information to the Board:

a. Evidence of abstinence from the use of non-medically prescribed drugs and alcohol;

b. Documentation that she is rehabilitated and competent to practice nursing by submitting:

i. A comprehensive drug/alcohol evaluation completed by a qualified health care provider at the time of application for reinstatement.

ii. A detailed summary of employment since licensure revocation or suspension; and

iii. Documentation of activities engaged in to address drug/alcohol issues, to include documentation of an active recovery program.

3. The Board reserves the right to assess investigative costs and attorney fees incurred in this matter as a condition of reinstatement.

This order is effective immediately.

DATED this 24th day of April, 2006.

IDAHO STATE BOARD OF NURSING

By [Signature]
Randall Hudspeth, N.P., C.N.S., R.N.
Chairman
NOTICE OF DUE PROCESS RIGHTS

This is a final order of the Board. Any party may file a motion for reconsideration of this final order within fourteen (14) days of the service date of this order. The Board will dispose of the petition for reconsideration within twenty-one (21) days of its receipt, or the petition will be considered denied by operation of law. See Idaho Code § 67-5246(4).

Pursuant to Idaho Code §§ 67-5270 and 67-5272, any party aggrieved by this final order or orders previously issued in this case may appeal this final order and all previously issued orders in this case to district court by filing a petition in the district court of the county in which:

a. A hearing was held,

b. The final agency action was taken,

c. The party seeking review of the order resides, or

d. The real property or personal property that was the subject of the agency action is located.

An appeal must be filed within twenty-eight (28) days (a) of the service date of this final order, (b) of an order denying petition for reconsideration, or (c) the failure within twenty-one (21) days to grant or deny a petition for reconsideration, whichever is later. See Idaho Code § 67-5273. The filing of an appeal to district court does not itself stay the effectiveness or enforcement of the order under appeal.
AMENDED
CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 8TH day of MAY, 2006, I caused to be served a true and correct copy of the foregoing by the following method to:

Monica Nilsson
2932 E. Black Forest Avenue
Post Falls, ID 83854

☐ U.S. Mail
☐ Hand Delivery
☒ Certified Mail, Return Receipt Requested
☐ Overnight Mail
☐ Facsimile: _________________________
☐ Statehouse Mail

Karl T. Klein
Deputy Attorney General
P.O. Box 83720
Boise, ID 83720-0010

☐ U.S. Mail
☐ Hand Delivery
☐ Certified Mail, Return Receipt Requested
☐ Overnight Mail
☐ Facsimile: _________________________
☒ Statehouse Mail

Sandra Evans, M.A.Ed., R.N.
Executive Director
Board of Nursing
RULE 132.04.
VOLUNTARY SURRENDER OF LICENSE

I, [Name], by affixing my signature hereto, acknowledge that:

1. I admit that I have engaged in the following conduct: [description of conduct]

2. I understand that the admitted facts constitute grounds for disciplinary action pursuant to the Nursing Practice Act, Idaho Code §54-1413(1) and the rules of the Board, IDAPA 23.01.01, et seq. I also understand that the Board of Nursing has the authority to accept this voluntary surrender pursuant to Idaho Code §54-1413(2)(a).

3. I am aware that, without my consent, no legal action can be taken against me, except pursuant to the Idaho Administrative Procedures Act, Chapter 52, Title 67, Idaho Code.

4. I understand that I have the following rights, among others: the right to a formal fact finding hearing before the Board; to reasonable notice of said hearing; to representation by counsel; to present evidence and testimony on my behalf; to compel the testimony of witnesses; and to cross-examine witnesses against me; and

5. I waive all such rights, including the right to a formal disciplinary hearing.

6. I also waive the right to challenge the board for bias in the event that charges concerning these admitted facts or any other matter involving my license are brought before the board.

7. In lieu of a formal disciplinary hearing, I hereby voluntarily surrender license number [license number] and will immediately discontinue the practice of nursing in Idaho.

8. As required by Board of Nursing Rule 132, IDAPA 23.01.01.132.04, I agree to enter treatment immediately, to participate in a monitoring program and to resume the practice of nursing only at such time as a conditional limited license has been issued to me.

9. I understand that Board of Nursing representatives will, if questioned, report the status of my license as "surrendered."

DATED: 9-6-05

[Signature of Licensee]

DATED: 9-6-05

6/99-PRN

[Signature of Witness]

Exhibit A

Page 1 of 1
NURSE MONITORING CONTRACT

Client Name: Monica Nilsson

Date: 10-20-05

I, Monica Nilsson, recognizing that I suffer from chemical dependency and/or mental conditions that may impair my ability to practice nursing safely, desire to enroll in the Program for Recovering Nurses. During my recovery process I agree that I will complete the following activities to obtain the support of the PRN:

Initial I agree to abstain from the use of alcohol and all other legal and illegal drugs unless they are prescribed for health care reasons.

Initial I agree to provide my selected healthcare provider with a copy of this agreement and ask healthcare provider to provide the PRN with a copy of any prescription given to me including reason for the prescription, dosage, length of use, and # of refills.

I agree to advise the following persons of the conditions of this agreement:

* Initial *Work Supervisor
*Initial *Spouse or significant other
*Initial *Primary Care Provider/Dentist
*Initial *Other

I agree to participate in and attend regularly in the following activities:

* Initial *Attend Relapse prevention groups * Contact PRN by 10/27/05 with location of all
* Initial *3 Mutual Support Group Meetings per week
* Initial *Meet weekly with sponsor face-to-face to work the steps
* Initial *Random UA/Drug Testing
* Initial *Weekly Health Professionals Support group

Initial I agree that if I am convicted of any felonies, I will no longer be eligible to remain in the PRN as a non-board referral and the PRN will inform the Board of Nursing of this conviction.

Initial I agree to accurately describe my weekly recovery activities (as outlined above) on the forms provided and submit weekly monitoring reports to the independent monitoring service.

Initial I agree that if I do not adhere to the conditions of this contract, the Program Coordinator may elect to notify those referral sources specified on the release of information form, that I have signed, of such default.

Initial I agree that the Program Coordinator and those specified on the release of information form that I have signed may exchange information pertinent to this agreement.

Initial I will be responsible for payment of regular drug tests, treatment costs, and monitoring fees and will remain current with these fees.

Initial I agree to meet with the Program Coordinator, or other representatives of the Program, whenever requested to discuss my progress.

Initial I agree that this contract can be reviewed and modified as appropriate for a minimum of five (5) years. I understand that all requirements on this contract, including financial obligations, must be fulfilled or I will be reported to the PRN Advisory Committee for non-compliance. This report may result in recommendation for disciplinary action to the Board of Nursing.

Client Signature: [Signature]

Witness: [Signature]

Program Coordinator: [Signature]
Program for Recovering Nurses

Terms and Conditions for Participation in the PRN

The Idaho Program for Recovering Nurses agrees to monitor me in my efforts toward a program of recovery among my peers, family and medical community, and where appropriate, reporting to the Board of Nursing or other designated entities. Positive reports to appropriate sources are contingent upon compliance with my contract and this agreement and therefore can be withdrawn for violation of either document. I acknowledge, understand and agree that if I fail to meet the conditions of my PRN contract, the PRN will report my non-compliance to the State Board of Nursing and any other appropriate source (i.e.: probation, employer).

Moving to Another State

- I shall not practice nursing in another state without first notifying the Board of Nursing in that state of my participation in the Idaho PRN and receiving authorization from that Board to begin practice.
- I shall continue to comply with my PRN contract while residing and/or practicing outside this state unless I enter into a substantially identical agreement with the receiving Recovery Assistance Program or State Board of Nursing or agree to surrender my license for cause. I shall notify the PRN in writing of all dates of departure and return from this state to reside and/or practice outside the state. If I elect to reside and/or practice outside the state during the PRN contract, I authorize the PRN to provide a copy of my PRN contract to the receiving Recovery Assistance Program and/or State Board of Nursing.
- Should I become licensed and begin practice in another state, I understand that the Program for Recovering Nurses will refer my case to the receiving Recovery Assistance Program or its equivalent in that state and coordinate efforts between programs. Should the state not have such a program, the Program for Recovering Nurses shall refer the case to the Board of Nursing in that state.
- In the event I move permanently, locally or out of state, I shall notify the PRN and Board of Nursing within five days, in writing, of the new address and telephone number.
- It is notated that while practicing under conditions of limited licensure, I may not be employed in any other state party to the Nurse Licensure Compact without receiving express permission from that state.

Returning to the Workplace

- I understand that it is my responsibility to notify any nursing employer of my relationship with and participation in the Program for Recovering Nurses.
- I will emphasize the importance of my recovery and monitoring contract requirements to my employer so that my work schedule or environment does not compromise or jeopardize my recovery or my compliance with the contract. Recovery shall remain my top priority.
- I shall not return to work until I receive written approval from the PRN and support of my treatment provider. In the event that I change positions or seek new employment, I shall obtain approval from the Program for Recovering Nurses at least two weeks prior to accepting the position. To begin working, I must have a work monitor in place, as arranged by the Program for Recovering Nurses and all releases must be signed for the hiring facility.
- My restrictions may include: no access to the narcotic keys or controlled substances (including any mood altering drugs), no work in an ER, CCU, ICU, OR, recovery room, and/or delivery room, and no employment with a temporary agency or in home health, unless prior approval is obtained from the PRN. Any change in restrictions may be requested and—upon approval—will be reflected in my contract.
- I will not work the night/graveyard shift (11pm-7am), will not rotate shifts, float units or work any over-time (excess of 40 hours per week in the nursing field) without written approval of the Program for Recovering Nurses.

UA Testing

- It is my responsibility to timely notify the Program for Recovering Nurses of a missed drug screen or missed daily call in to NCPS.
- Any confirmed positive drug screen, or failure to test, for which the Program for Recovering Nurses has not received appropriate notification and prescription documentation from the
prescribing provider will be considered a relapse. My employer will be notified immediately of the positive screen. My case will then be reviewed by the PRN with possibility of a re-evaluation or report of my relapse to the Board of Nursing Advisory Committee for consideration of continuation in the program. If it is a second relapse, I understand I will be referred to the Board of Nursing Advisory Committee for consideration of continuation in the program or referral to the Board of Nursing for possible disciplinary action against my nursing license.

- I shall give written notification to NCPS and the PRN one week prior of any inability to screen. If I fail to notify the PRN and/or NCPS of my inability to screen and then fail to screen, I will be considered non-compliant with my contract with the Program for Recovering Nurses.
- I agree to insist that an appropriate urine sample will be taken immediately anytime my integrity may be questioned in my professional environment.
- I am aware that consuming large quantities of liquids prior to giving my urine specimen may result in a dilute urine, indicating "Dilution" or "Substitution" according to federal guidelines, which can appear to be an effort on my part to hide use. I understand that I should not drink more than 12 ounces of fluid within three hours prior to testing. I understand that I should avoid any diuretics, including the caffeine found in coffee, tea and some sodas. I understand that if it is necessary for me to drink large amounts of fluids or use a diuretic, I will do so after I provide my specimen. If I have just consumed large amounts of liquid and then notified that I need to test that day, I understand that I should wait a few hours for the fluid to clear before I provide a specimen. I also understand that if my specimen is dilute, it will be given to the Medical Review Officer for review, resulting in an extra charge, and possibly resulting in a failed review that indicates non-compliance with this contract.

**PRESCRIPTION DRUG / HEALTH CARE**

- I shall, in general, consult only one health care provider (primary care provider) for my health care needs and fill prescriptions only at one pharmacy. I agree to immediately notify my provider that I am enrolled in the Program for Recovering Nurses, of my addiction/abuse problem, and any drug restrictions I have. If for some reason I am not able to see that physician when necessary, I will contact PRN as soon as possible so a release can be signed. I shall not obtain the same or equivalent prescription drug from more than one provider, or under any other circumstance which causes there to be available prescription drugs in quantities or types that are not medically required. Emergency prescriptions must be documented as such by the emergency physician and such documentation must be forwarded to the PRN within 48 hours. Additionally, I agree to notify any and all health care providers, from whom I receive treatment, of my participation in the Program for Recovering Nurses prior to receiving treatment.

- Should I be prescribed any medication (including antibiotics or a new medication), or if any dose of a current medication is changed, it is my responsibility to have the prescribing provider fax the prescription from his/her office directly to the PRN office (208-323-9222) within 24 hours. I understand that I need to have the provider include in the documentation the following information: the physician's name clearly indicated, the medication prescribed, the dosage and frequency, how many refills, the reason for prescribing the medication, and the duration I will be taking the medication. If for some reason my physician is not willing to fax the prescription from his/her office, I must fax the prescription and necessary information to the PRN office before it is filled.

- I will not use prescribed medications for any reason other than for what they are prescribed. If my physician wants me to use the medication for a use other than for what it was originally prescribed, he/she must contact the PRN office and submit the reason for the use in writing. All communications with my physician must occur before I begin using the medication. Use of prescribed medications, other than for the initial intent, must be properly verified in writing by my physician as described above. If I receive a positive test for a medication that was not taken as prescribed by my physician, and proper verification was not received by the PRN, the test will be considered failed.

- Any time my physician prescribes a narcotic medication for me, I will discuss with him/her an appropriate length of time that it will be necessary for me to take the medication. I will ask my physician to write this appropriate length for use on the prescription when he/she factes it to PRN.
If longer use is needed other than what was originally stipulated, my physician must notify the PRN office in writing before I will continue to use the medication. When use of the prescribed narcotic medication is no longer needed, I will dispose of the medication PROMPTLY. A witness must be able to verify that this disposal occurred. (For your convenience, the PRN will provide a form for you and your witness to confirm the disposal. You must use this form when disposing of ALL medications prescribed to you and then fax or send the completed form to the office within 24 hours of the disposal.) If I receive a positive test for taking medication after the appropriate length of time determined by my physician, the test will be failed.

- Any time over-the-counter medications (other than ibuprofen, aspirin, and/or acetaminophen), herbal supplements, or stimulant drinks are used, I will contact the PRN office within one week of starting the over-the-counter medication, herbal supplement, or stimulant drink. I must notify the PRN of the date I started using the medication, herbal supplement, or stimulant drink, estimated finish date, and what the medication, herbal supplement, or stimulant drink was being used for. If the PRN is not notified of the use of an over-the-counter medication, herbal supplement, or stimulant drink, and a positive test occurs, that test will be failed by the Medical Review Officer.

- If I find the need to take over-the-counter or prescription medications frequently, I will contact the PRN office, my physician, and my sponsor immediately to discuss this situation. If my physician recommends the frequent use of a particular medication, I will have his/her written notification that he/she approves of the continued use forwarded to the PRN.

- I shall immediately notify the Program for Recovering Nurses if I am hospitalized or must undergo any procedures requiring the administration of medications, and to provide all required documentation from any and all health care providers of the procedure and any medications involved prior to, during, or after the procedure.

- I shall not write, fill, or otherwise order controlled substances for myself or my immediate family.

- The PRN strongly advises me, as a nurse, not to practice nursing while having any narcotic medications in my system.

**TERMS AND CONDITIONS OF THE CONTRACT**

- The minimum term for the PRN contract is five (5) years. However, if problems occur, such as relapse or non-compliance, the PRN may extend the contract beyond five years.

- The PRN reviews contracts on an annual basis, and thus may make changes in this contract appropriate for my progress in recovery. However, if my circumstances change, such as relapse, non-compliance, etc., then the PRN may make changes on my contract at any time.

- All changes in my contract(s) will be documented by the PRN. If I desire to, I may appeal any contract changes in writing to the PRN and/or by appearance at the next Board of Nursing Advisory Committee meeting. I may request a change in the contract at any time by sending a written request and supporting reason for the request. The request will receive prompt attention, although a final decision on the request may be delayed until the next scheduled quarterly Committee meeting.

**ADMONITIONS**

- No self-prescribing any drug, legend or scheduled (controlled).

- Avoid poppy seeds, chiefly in pastries. I understand that if I eat small amounts of poppy seeds or food containing poppy seeds, it may result in a positive test for opiates. PRN will not accept eating such food as an explanation for the presence of drugs in a urine test.

- Avoid non-beverage alcohol: for example, mouthwash, liquid medication with alcohol base, desserts, food cooked in alcohol, Primatene Mist, vanilla extract, etc.

- Do NOT consume so called “non-alcoholic” beer and/or wine.

- Beware of iatrogenic relapse (from prescription medications). Inform any prescribing practitioner (M.D., D.O., D.P.M., D.D.S., D.M.D., A.P.P.N., etc.) that you are chemically dependent and to check with the PRN in advance, unless in an emergency, and then as soon thereafter as possible.

- Keep any family member’s medication(s) in a location distinctly separate from your medication(s) to avoid accidental contamination and/or ingestion.

Last Revision 10/30/03
Scrutinize all labels on any medications or other preparations you take before actually putting them in your mouth. Be sure to read all the labels in adequate light to ensure it does not contain addictive chemicals.

Remove all alcoholic beverages and other non-beverage alcohol (as above) from your home, office, boat, and vehicles (this includes wine collections).

Avoid the "PERCEPTION:" for example, sitting at a bar consuming soft drinks, exiting a liquor store carrying a package, drinking sparkling cider out of a champagne glass at a wedding, or being in attendance at a raucous party situation.

Avoid unexcused absences (from meetings, urinalysis tests, etc).

Avoid positive UA’s (MISSDUA = POSITIVE UA).

Failure to submit a urine sample or failure to submit a specimen of sufficient quantity or temperature will be reported as a positive screen.

Avoid missing payment of program, treatment, and UA fees, as this is considered non-compliance.

In the event of an adverse situation in the employment setting, cover yourself with a UA, preferably at our laboratory, but certainly at the nearest convenient facility.

AVOID AT ALL COSTS A FRAUDULENT APPLICATION! If questions regarding chemical dependency are worded ambiguously, or if there is any reasonable doubt about the intent of an inquiry, or if you are not absolutely certain of the proper and rigorously honest answer, consult with the Program Coordinator before answering the question.

Don’t "advertise" your addiction or your recovery.

MISCELLANEOUS GUIDELINES

I agree that I will maintain a current release of information with my treatment provider to facilitate communication between the provider and the PRN.

I will notify the PRN of any change of address or telephone number in writing within 5 days of changing said information.

I understand that my failure to fulfill, in a timely manner, any one or more of the designated requirements of the PRN contract, including the related financial obligations, will result in the immediate notification of non-compliance to the Board of Nursing Advisory Committee, which may result in a recommendation to the Board of Nursing for further disciplinary action on my license. This notification to the Committee may provide the basis for the filing of disciplinary charges against me, which—if proven—could result in the imposition of sanctions, including revocation, of my right to licensure.

In the event that the coordinator for the Program for Recovering Nurses determines that I have failed to fulfill any one or more of the requirements of the contract and notifies the Board of Nursing Advisory Committee of that failure, I hereby waive any right or claim to confidentiality of any program files concerning me and grant the Board of Nursing access to all information. This waiver will include any and all medical or other files pertaining to me, including any memoranda, documents, correspondence, reports, interviews or interview notes, monitoring notes or monitoring reports, or any other information contained in those files.

The PRN contract will remain in effect until I have documented five years of continuous recovery from alcohol and drugs of abuse—unless the treating health care professional/physician establishes the need in writing for continued limitation and/or continued monitoring of participant’s practice beyond that time. After the minimum term, I may request, in writing, a discharge from the program. The documentation of compliance with all terms and conditions of the contract will be reviewed.

**I have read and agree to abide by the above listed guidelines and admonitions of the PRN program.**
March 6, 2006

To The Board of Nursing,

This letter is to inform you that I will no longer be participating in the PRN program. I feel Nursing is not the profession for me and will be starting school soon to establish a new profession. The expense of PRN is too much since I will be paying for school and childcare.

I understand the Board will take action at an administrative level by taking my license for 2 years. After 2 years I could ask for my license back and would need to show proof of my sobriety. There would be a fee involved at that time and I would need to follow the Boards direction if I should choose to reinstate my license. This is my understanding after talking with Linda Coley and that no legal charges would be filed. If I have misunderstood any of this please notify me before removing me from the program.

I wish to thank the Board of Nursing and PRN for allowing me to be in this program and being so helpful. It is a wonderful service you have provided. I would like for you to encourage other nurses to get involved the Celebrate Recovery program that I have really found to be the most helpful. It is usually run by a Church. I will continue my involvement in my recovery and am looking forward to starting a new career.

Sincerely,

Monica Nilsson
U.S. Postal Service
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com
OFFICIAL USE

Postage $6
Certified Fee
Return Receipt Fee (Endorsement Required)
Restricted Delivery Fee (Endorsement Required)

Total Post:

Sent To:
MONICA NILSSON
2932 E BLACK FOREST AVENUE
POST FALLS ID 83854

PS Form 3800, June 2002
See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

1. Article Addressed to:
MONICA NILSSON
2932 E BLACK FOREST AVENUE
POST FALLS ID 83854

COMPLETE THIS SECTION ON DELIVERY

A. Signature
MONICA NILSSON

B. Received by (Printed Name)
MONICA NILSSON

C. Date of Delivery
MAY 11
2006

D. Is delivery address different from item 1? Yes
If YES, enter delivery address below:

3. Service Type
Certified Mail
Registered
Insurance

4. Restricted Delivery? (Extra Fee) Yes

PS Form 3811, February 2004
Domestic Return Receipt
102595-02-M-1640