

Delaware Professionals' Health Monitoring Program Monitoring Agreement

I, _____, accept and understand the terms of this agreement with the Delaware Professionals' Health Monitoring Program (DPHMP) as well as my personal Addenda, if any, and agree to be bound by the terms of these documents for a term as noted on my addendum to the monitoring agreement. The term begins on my enrollment date.

- 1) I understand that my enrollment date will be the date my completed consent forms, Monitoring Agreement, and credit card authorization for toxicology testing, if applicable, are received by DPHMP and that I must continuously comply with any Monitoring Agreement and personal Addenda from my enrollment date throughout the term of my Monitoring Agreement specified above.
- 2) I understand that in order to successfully complete the Program, I must have at least two consecutive years of continuous compliance with my Monitoring Agreement and personal Addenda. Continuous compliance for licensees previously enrolled in the Voluntary Treatment Option Program with a lesser term of agreement period must have continuous compliance for the remainder of their agreement.
- 3) I understand that I must comply with any rules adopted by my licensing board or commission regarding participation in the DPHMP and that it is my responsibility to keep informed about these rules.
- 4) I agree to step-down from employment on my enrollment date and remain out of work until a third-party evaluation is completed. I agree to pay for this evaluation and understand the evaluator's initial treatment or continuing care plan and any subsequent treatment or continuing care plan I receive will become a personal Addenda to my Monitoring Agreement. I will actively participate in all treatment and continuing care plans, including any restriction that I remain out of work for a period of time, or return to work with limitations. I understand that simply attending group or therapy sessions does not constitute active participation. I understand I may be asked to obtain, at my own expense, additional third-party evaluations during the term of my Monitoring Agreement to assess if modifications should be made to my treatment plan or prior to completion of the program.
- 5) I understand that my Monitoring Agreement may be changed over time as I progress through treatment and the DPHMP and I agree to execute any addendum to the Monitoring Agreement requested by the DPHMP.
- 6) I will sign all release of information authorizations for the exchange of information between the DPHMP; DPR; third party evaluators; treatment providers; and if applicable, my employer, family, and significant others.
- 7) I will sign all release of health information authorizations, including but not limited to drug, alcohol and mental health treatment records requested by the DPHMP.
- 8) I understand the DPHMP will not provide me with any diagnosis or treatment for any condition that I might have.
- 9) I understand that my treatment providers will be required to submit monthly written status reports to the DPHMP regarding my progress. I understand that it is ultimately my responsibility to obtain the documentation required by the DPHMP.
- 10) I agree to initially contact the DPHMP twice a month by telephone and speak with the agreement monitor. After three months, if I have been fully compliant with my Monitoring Agreement and any personal Addenda, I understand I may contact the monitor via email or voice mail. However, even following three months of compliance, I understand that at least one of my two contacts per month must be telephonic. At the time of each

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute the patient.

contact, I will advise the agreement to monitor of the number of self-help meetings I have attended, my frequency of contact with my sponsor and treatment providers and any changes to my employment, address, health, family, etc.

- 11) I agree to obtain any medical or psychological testing that may be requested by my evaluator, treatment providers, or the DPHMP.
- 12) If requested, I will cooperate with a fitness to practice evaluation prior to returning to work. Upon returning to work, I will follow any limits that have been placed on my professional practice.
- 13) I will completely abstain from alcohol, illegal substances and stimulants, narcotics, sedatives, and tranquilizers and all other mind altering and/or potentially addicting medications, not prescribed by my prescribing physician for a specific medical condition and approved by DPHMP. I will completely abstain from over-the-counter medications containing alcohol or hemp products and from over-the-counter medications that affect the central nervous system, unless approved by my prescribing physician and all food items containing alcohol, poppy seeds or other substances that may produce a positive test result for drugs or alcohol.
- 14) I will not use medical marijuana during the term of my Monitoring Agreement.
- 15) In the event I am prescribed a mood altering or intoxicating substance or potentially addictive drug, I will immediately inform the DPHMP and request approval prior to use. I will fax a copy of the prescription to the DPHMP and have the prescriber complete a Medication Management form.
- 16) I understand that I may have only one prescriber and only one pharmacy for all mood altering or intoxicating substances or potentially addictive drugs. Any exception from this requirement must be approved by the DPHMP. I understand exceptions will be made only in extraordinary circumstances.
- 17) I will sign any release of information forms that are needed for any prescribing person to consult with the DPHMP.
- 18) I will report to the DPHMP my use of any mood altering or intoxicating substances or potentially addictive drugs within 24 hours of use. This includes unauthorized or inappropriate use of prescription medications.
- 19) If applicable, under no circumstances will I write prescriptions for any mood altering or intoxicating substances or potentially addictive drugs for myself, members of my family, or anyone with whom I do not have an appropriate prescriber-patient relationship and *bona fide* medical justification.
- 20) I will inform my personal physician of the conditions of this Monitoring Agreement and request that he or she not prescribe any mood altering or intoxicating substances or potentially addictive drugs for me, unless there is no reasonable alternative. For non-emergent conditions that my physician believes warrant the use of mood altering or intoxicating substances or potentially addictive drugs, I will contact the DPHMP and apply for permission to use the drug in question. I agree to inform the DPHMP if I change my personal physician within one week of implementing that decision. I agree to sign an Authorization to Use and Disclose Protected Health Information for my current personal physician and for any future personal physician. If I do not have a personal physician, I understand that it is recommended to obtain a personal physician and initiate a complete physical examination at the time of program enrollment, and that I may be required to initiate and complete a physical examination due by my evaluator or treatment provider.
- 21) If I am employed, I will identify an appropriate person who could serve as a workplace monitor per the DPHMP established parameters, including but not limited to: my workplace monitor will not be a relative or have a prior social relationship with me; must have an unencumbered license; and may not be my employee. I will inform my

workplace monitor of my status with the DPHMP and of my need to be in the DPHMP within 24 hours of enrollment in the DPHMP. I will meet with my workplace monitor with the frequency determined in my personal Addenda to document my progress complying with my Monitoring Agreement and personal Addenda. I am aware and agree that my workplace monitor will be periodically contacted by the DPHMP and will be asked to provide a monthly assessment of my ability to comply with my Monitoring Agreement and personal Addenda that is due by the 5th day of each month. I understand that my workplace monitor will contact the DPHMP in the event my behavior indicates concern. In the event my workplace monitor is no longer able to serve in this capacity, I will notify the DPHMP within 24 hours of acquiring this knowledge.

- 22) I will establish a toxicology testing schedule and account with DPHMP if requested. I understand I am required to use an approved testing notification system every business day (Monday through Friday, excluding Delaware state holidays and the Friday following Thanksgiving) from 5:00 a.m. to 7:00 p.m. EST to determine if I must undergo toxicology screening on that day. These approved notification systems include the DPHMP's Interactive Voice Response system (IVR), the webpage and the app. I will check the appropriate panel on my Chain of Custody form as directed by the approved testing notification system. I understand that if I miss four check-ins within a 365-day period, an additional test will be scheduled, and an additional test will be scheduled for every subsequent missed check-in.
- 23) I will submit to any and all drug and alcohol testing required by the DPHMP. I understand that testing may or may not be random, monitored or directly observed. I understand I must test prior to the closing of my assigned collection site on the day I am scheduled to test. It is my responsibility to confirm my collection site's hours of operation. If I fail to test as scheduled I understand I will be in violation of my monitoring agreement. I will follow the DPHMP's established toxicology testing guidelines received with the enrollment packet.
- 24) I will submit to urine and blood testing as requested, and I understand that I am responsible for the cost of all toxicology testing.
- 25) If I am using a paper chain of custody form, I will check the appropriate panel on my chain of custody form as directed by the approved testing notification system.
- 26) If I am not currently enrolled in the toxicology testing program, I understand that I am not required to currently provide urine screens. I understand that if requested by the DPHMP, I must agree to toxicology testing and will submit to any and all drug and alcohol testing required by the DPHMP. I understand that testing may be random, monitored or directly observed. I will be available for such testing on the same day on which I am scheduled to test. I will follow the DPHMP's established toxicology testing guidelines and procedures received with the enrollment packet. I will be available for toxicology testing 5 days a week. I will use an approved testing notification system on a daily basis, excluding Saturday and Sunday and State recognized holidays.
- 27) I understand that if I participate in the toxicology testing program, I must share any medical problem that may prevent me from giving a urine sample prior to beginning the program. I understand that a failure to produce the required 45mL specimen will be reported as a failure to test. A failure to test is substantial noncompliance with my Monitoring Agreement and will be reported to the DPR who may in turn suspend my license.
- 28) I understand that if I participate in the toxicology testing program, any evidence of mood altering or intoxicating substances or potentially addictive drugs in the specimen sample can result in a change in my Monitoring Agreement or a report of substantial noncompliance to DPR who may in turn suspend my license. I understand that it is my responsibility to avoid substances that could result in a non-negative toxicology report, e.g., poppy seed bagels and the excessive use of alcohol-based hand sanitizers.
- 29) I agree to provide the DPHMP with 14 days notice prior to any travel plans so I can receive my collection site, testing supplies and Chain of Custody forms. I understand that I will remain subject to all conditions of this Monitoring Agreement regardless of travel destination.

- 30) I will report any arrest for or conviction of any misdemeanor or felony to the DPHMP within 3 business days after such arrest or conviction.
- 31) I will report to the DPHMP any applications for licensure in other states, changes in employment, changes in practice setting, changes in telephone numbers and changes in residence within 3 days of said changes. I understand that a change in practice setting or employment may require prior approval from the DPHMP. If I am a licensed nurse, I understand I will be provided a license that will be marked "valid in DE only" upon enrollment in the DPHMP.
- 32) I will pay for the following services: third party evaluations, all treatment received, toxicology testing, and fitness to practice evaluations. I understand that I pay the DPHMP directly for the toxicology testing and I pay the providers for all other services. I understand that maintaining a zero-balance due is a requirement of my Monitoring Agreement. I understand that I have 48 hours to pay my account if I fail to maintain a zero-balance due. I understand that if I do not pay my account, I will not be able to continue in the toxicology testing program and this will be reported to the DPR as substantial non-compliance. DPR may in turn suspend my license.
- 33) I agree to return any calls from the DPHMP within 24 hours or respond to any message to call on an approved testing notification system within 24 hours.
- 34) I understand that my professional licensing board may not discipline me solely because I participate in the DPHMP; have been diagnosed with a substance use disorder; and/or have been diagnosed with a mental health disorder.
- 35) I understand that if I test positive for a mood altering or potentially addicting medication and my prescription is more than 6 months old, I will be non-compliant. I understand that all prescriptions for mood altering and potentially addicting medications must be approved by the DPHMP and my prescribing physician must complete a medication management form. I must submit all prescriptions to DPHMP.
- 36) I understand that any failure to comply with this Monitoring Agreement will be immediately reported to my workplace monitor along with the date non-compliance occurred, a complete description of the non-compliance, and possibly, a recommendation that the licensee step down from employment until a third-party evaluation can be completed. If I am self-employed, I may be required to sign a Refrain from Practice document and step down from my private practice. Non-compliance with my Monitoring Agreement may also result in the modification of my Monitoring Agreement, including but not limited to any of the following singularly or in combination: extension of the duration of my Monitoring Agreement, increased testing, loss of exemption days, mandatory third-party evaluation, and possible automatic suspension of license. I further understand that any substantial non-compliance on my part with the terms of my Monitoring Agreement will result in my termination from the DPHMP and will be reported to the DPR, who may in turn suspend my license. Substantial non-compliance includes, but is not limited to the following:
- The failure to contact the Program or return enrollment paper work within ten business days when referred by a board, commission, or third party;
 - A pattern of failure to comply with the Monitoring Agreement or its addendum;
 - Any report of drug diversion in the workplace;
 - Any violation of a work or practice restriction imposed by the Monitoring Agreement, addendum, or board or commission order;
 - Behavior that results in the death or injury of a patient or client, including but not limited to inappropriate sexual behavior;
 - The failure to maintain a positive balance in my toxicology account or the failure to remain current with payments for toxicology testing; and
 - Any event, including but not limited to any non-compliance event that, at the discretion of the DPHMP, taking into account all relevant circumstances, should be treated as a substantial non-compliance event.

- 37) I understand that successful completion of the DPHMP requires two consecutive years of full compliance with my Monitoring Agreement and Addenda with no non-compliance events. I understand that non-compliance may require my Monitoring Agreement term to be extended beyond the term indicated on page one.
- 38) I understand that my failure to comply with any of the terms of my Monitoring Agreement or its Addenda may be reported to the DPR and cause to be activated an immediate investigation and institution of disciplinary proceedings if appropriate. If a referral is made for investigation and discipline, I hereby consent to the emergency suspension of my license for a period of no more than sixty days pending a hearing before my professional licensing board, panel, or DPR hearing officer.
- 39) I understand that my mental health records and protected health information are protected under the Health Insurance Portability and Accountability Act of 1996.
- 40) I understand that my alcohol and/or drug treatment and mental health records are protected under federal and state laws and regulations (42 CFR Part 2) governing confidentiality of alcohol and drug abuse patient records and protect health information records generally and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke my consent to release such records at any time except to the extent that prior action has been taken in reliance upon it. I understand that for my revocation of consent to be effective, it must be in writing. I understand that if I revoke my consents, my name will no longer be on the active list and the DPR will know that I have revoked consent because they will not receive any notification of my completion of or termination from of the Program.

DATED this _____ day of _____, 20_____.

Signature of Licensee: _____ Print Name: _____