Alabama Physician Health Program

Assistance Agreement

Chemical Dependence

The Alabama Physician Health Program, APHP, is sponsored by the Medical Association of the State of Alabama, MASA and the Board of Medical Examiners. The Alabama Physician Wellness Committee, APWC, appointed by the Board of Medical Examiners, oversees and directs the program. The purpose of the APHP is "to provide a supportive program to Alabama physicians, residents, medical students, physician assistants, and their families by assisting the professional with remedial health problems that cause impairment, and to protect patients, by promoting early identification and intervention, overseeing evaluation and rehabilitation, and monitoring to provide documentation of well-being for the professional." The purpose of this agreement is to establish a program to objectively document successful recovery, to detect relapse early, should it occur, and to promote accountability to improve outcomes.`

Last Name _____First Name:_____ DOB:_____ SSN: _____

Addresses

Home:_____
Street Address City State Zip

Office:_____
Street Address City State Zip

Other: ( ) _____
Street Address City State Zip

Other: ( ) _____
Street Address City State Zip

Phones, etc.

Home Phone: ( )_____Office Phone: ( )_____ Beeper: ( )_____

Mobile Phone: ( )_____Fax: ( )_____ Other ( ): ( )_____

Email Address: _____ Date: _____

(Please place an asterisks beside preferred address(es) and telephone number(s). We will use your cell or office phone and mail will be sent to your home address marked "Confidential and Personal" unless otherwise indicated.)

Significant other or emergency contact: Name:_____PHONE: ( )_____

Term of Agreement

1. I, _____, M.D. agree to the terms of this agreement for a **period of five (5) years** from the date of this agreement. Alterations cannot be made without prior approval from the medical director. Failure to adhere to the terms of this agreement may result in a report being made to the Alabama Board of Medical Examiners. _____(Initials)

Toxicology Testing

2. I agree to **abstain** at all times during the term of this agreement from any and all potentially addictive chemicals whether over-the-counter, scheduled or unscheduled (including but not limited to alcohol (ie ethyl alcohol or ethanol), marijuana, tranquilizers, sedatives, stimulants, narcotics, opioids including ultram (tramadol), nubain, soporifics, androgenic steroids, or any other known addictive drug) except as prescribed by my physician and only after consultation with APHP. If any mood altering and/or potentially addictive medications are required or

recommended by my physician I will notify APHP, in advance if possible, and provide documentation of the need for the medication (i.e. note from the prescribing physician) within 3 days. If the need for the medication is ongoing, I will renew verification every 90 days. I also agree to avoid exposure to anything that will cause my urine drug test to be positive. In that regard I will avoid such items as "hemp oil" "coca tea" and I will not consume poppy seeds (which can be found in curry sauces, breads, salad dressings, and in or on other foods). I will not use ethyl alcohol in any form (including alcohol "free" wine or beer, over-the-counter drugs containing alcohol (cough syrup, Nyquil or other similar OTC drugs or supplements), mouthwash or other hygiene products containing ethanol, foods containing ethanol (desserts, vanilla extract, etc), communion wine, sanitizing hand or body gels (Purell or other), or any other form of ethyl alcohol). Intentional use of any of these products or medications without a physicians order is a violation of this agreement. _____(Initials)

3. I will submit to **toxicology screening** of urine/blood/sputum/hair (usually urine) as requested. These screening tests will be random and observed. Either APHP or my Physician monitor, with or without cause, may request additional tests. I will participate in random testing at least 3-5 times per month for six months and 11-13 per year thereafter for the duration of this agreement. I agree to adhere to the urine testing notification and collection procedures and protocols. I agree to call the 800 number provided on a daily basis, Mon – Fri, as directed. I understand my compliance with calling the 800 number is monitored and that if I fail to call on a given day that an additional test date will be added for each day I fail to call. I further understand that if the notification system fails or I do not receive notification to provide screening tests, within a reasonable period (e.g. approximately 3 times my usual testing frequency) it is my responsibility to notify APHP. I also agree that it is my responsibility to assure that lab personnel observe all urine specimen collections. If urine specimen collection is not observed the results are invalid. I further understand that if I do not provide a specimen on the day of notification it will be considered a **positive** screen and I may be required to undergo further evaluation . _____(Initials)

4. I agree neither to prescribe mood-altering chemicals to my family nor to keep samples of scheduled medications in my home. _____(Initials)

Primary Care Physician and Medical Treatment

5. I will secure a **primary care physician** to treat my medical problems and I give him/her authorization to communicate directly with APHP regarding my progress and/or regarding any relevant issues regarding my recovery and their medical care. I agree to release a copy of this agreement to be sent by APHP to my primary physician with a letter explaining the APHP program and my participation. My physician will be: ._____ M.D., Phone_____
Street _____City_____Zip_____
_____(Initials)

6. I will not treat myself but will contact my **primary physician** regarding any significant health related issue. _____(Initials)

Physician Monitor and APHP Reports

7. I understand that a **physician monitor**, specifically appointed to serve as a liaison between myself and APHP, is also appointed to assist me. I acknowledge my physician monitor to be: _____M.D.
Street_____ City_____
Zip_____ Phone _____. _____(Initials)

8. I will meet with my **physician monitor** on a quarterly basis or more often, if needed, to discuss my progress. I will provide to my physician monitor at each quarterly visit a list of all 12-step meetings I've attended with dates and locations, and all Caduceus meetings attended. I will also complete a self-assessment questionnaire and provide this to my monitor at the time of my quarterly visit. You may obtain additional "self-assessment" questionnaires from APHP office. I understand that my monitoring physician is an unpaid volunteer, familiar with recovery and APHP policies, and that it is my responsibility to assure that monitoring reports are sent and received by APHP. I understand that more frequent meetings with my monitoring physician, increased frequency

of urine testing, and/or further evaluation may be necessary if reports are not received promptly. _____(Initials)

Worksite Monitor

9. I agree to have a worksite monitor _____ Phone Number _____. I will ask my worksite monitor to write a brief note to APHP at least quarterly to verify my wellbeing. The note should include: 1. How often and how we are associated. 2. Appearance at work? And 3. Any perceived problems, incident reports, or other concerns. Criteria for worksite monitor: 1) frequent contact w/our physician-participant, 2) preferably in the same general field, 3) a neutral party (not a partner, political enemy, golfing buddy, etc), 4) sensitive to confidentiality, 5) must be approved by: A) the hospital, B) the physician-participant, & C) APHP. _____(Initials)

Therapeutic Monitoring Group

10. I agree to attend an assigned **Therapeutic Monitored Group, TMG**, meeting weekly for at least 24 months with a facilitator authorized by APHP. I agree to permit my facilitator _____ _____, telephone _____ to provide reports of my progress and to notify APHP immediately if I fail to satisfactorily advance in my recovery efforts. I agree to release a copy of my treatment records and a copy of this assistance agreement which will be provided by APHP to my TMG therapist. I will be responsible for all costs incurred with the TMG process (weekly therapy fees charged by the therapist). At the end of 24 months, I agree to abide by the facilitator's recommendations as to additional attendance at these meetings if warranted. _____ (Initials)

Caduceus Meetings

11. I will attend a weekly **Caduceus** group (Health Professionals support group). Location and contact information regarding Caduceus groups are available through APHP or at http://www.aphp.homestead.com/files/Caduceus_Meetings.rtf. _____ (Initials)

AA and IDAA

12. I will attend AA meetings daily for 90 days, and subsequently at least three **AA or NA** meetings per week. (Caduceus group meetings and aftercare groups may be counted as an AA meeting; however, I will always, throughout this agreement, attend at least one AA or NA meeting per week even if counting these other meetings.) _____(Initials)

13. I will secure an **AA/NA** sponsor and make regular (at least weekly) contact. _____(Initials)

14. I understand that it is important for my family to attend Al-Anon, Alateen, or other support groups, and authorize them to communicate directly with the APHP as needed. _____ (Initials)

15. I will join **International Doctors in AA, IDAA**, which is free, by filling out and mailing a membership application or joining online at www.idaa.org. I will attend annual meetings of IDAA and I will bring my family if possible. (Scholarships are available for this meeting for members and their families.) _____ (Initials)

General Conduct

16. I agree to maintain a non-professional status with all other participants in my therapy groups (Caduceus, TMG, etc) and with group leaders. This means no prescribing, advising, recommending, diagnosing or giving of drug samples or referrals. I will function only as a patient/participant in these settings. _____ (Initials)

General

17. I agree to notify APHP of changes in my office or home address or telephone number. _____(Initials)

18. In the event that I move from Alabama or practice in another state, I agree to notify APHP. _____ (Initials)

19. I understand that if I fail to meet the conditions of this agreement, I may lose the support of the APHP. In case of relapse I agree to abide by the recommendation for corrective action. Relapse and/or failure to meet conditions may require reporting to the Board of Medical Examiners. _____(Initials)

20. I am aware that the members of the APWC, the committee appointed by the Board of Medical Examiners to oversee the APHP, or the staff of the APHP may make inquiries to and receive information from any hospital at which I hold medical staff privileges, and any physicians or non-physicians with whom I associate in the practice of medicine, members of my immediate family, and my employer concerning any and all aspects of my compliance with the provisions of this Assistance Agreement. I agree to execute an authorization for release of information to APHP authorizing any physicians or other treatment agents whom I have consulted for care and treatment to release all information concerning my mental and physical health to the APWC. I agree to make full disclosure to physicians with whom I share office practice, or call schedule, so that they may be alert to signs of relapse. _____ (Initials)

Release of Information

21. During the course of this agreement, I give my permission for APHP, when requested, to provide information concerning my recovery status, including sending any health records or other reports to: (Initial all that apply)

    a. **The Alabama Board of Medical Examiners, BME**. (I understand that the BME may ask questions on my license renewal regarding potential impairment. Regarding such questions, if asked, I will answer the questions and advise the BME that I am a participant in APHP. Furthermore, I give permission for the APHP to provide information to the BME regarding my recovery, including a copy of this agreement, treatment records, and other information, if requested.) _____(Initials)

    b. My **medical liability insurance carrier** _____: I will examine my Malpractice Liability Policy or contact the company to ascertain if I have a reporting requirement. I give permission for APHP to provide information regarding my recovery, if requested, including a copy of this agreement, treatment records, drug test reports, and other information, as needed. _____(Initials)

    c. Other **physician/medical groups**: (List any other organizations with which you may need our support.)

    _____

    _____

    _____(Initials)

    d. The following are a list of <u>all</u> **hospitals** where I have privileges (including active, courtesy, or any other type of privileges). Adjacent to each hospital is a designated individual (representing the wellbeing program or similar function) at each hospital. I agree to notify each of these individuals regarding my recovery and participation in the Alabama Physician Health Program and allow the APHP to send a copy of this agreement, an explanation regarding our program, and progress reports if requested.

Hospitals	Designated Individuals (required)
_____	_____
_____	_____
_____	_____
_____	_____

    ____ (Initials)

22. I am aware and will inform, if necessary, anyone receiving reports from APHP, including all hospitals and physician groups in which I have an association, that APHP <u>only</u> provides assistance for me to the extent of my participation in the program, and not to my qualifications or competence as a physician. _____(Initials)

23. I will notify APHP of any hospital affiliation changes. _____(Initials)

24. I understand that APHP is not responsible for insuring compliance to restrictions or probationary orders issued by the Board of Medical Examiners or the Medical Licensure Commission or other state or federal regulatory agencies. I will inform all hospitals or other organizations for which I have requested assistance by APHP where I have privileges of this information. ____ (Initials)

25. I hereby release and hold harmless APHP and the APWC and any and all agents, servants, employees or consultants of the Medical Association of the State of Alabama or the APWC from any claims whatsoever arising out of actions taken by the APHP and the APWC in good faith without malice in furtherance of the objectives of this Assistance Agreement. _____(Initials)

26. Inherent in this contractual agreement is a requirement of the participant to be appropriately cooperative and courteous to the APHP staff and to pay fees promptly (to APHP, for urine testing, therapists, etc). _____(Initials)

27. I agree to pay the APHP participation fee of $180 per 6 month period for MASA members or $300 per 6 month period for non-members. _____ (Initials)

28. In the event it becomes necessary for the Alabama Physician Health Program to render a report to the State Board of Medical Examiners pursuant to Ala. Code §34-24-405, I authorize the Alabama Physician Health Program to release to the State Board of Medical Examiners any records in the possession of the Alabama Physician Health Program which relate to my participation in the APHP program including but not limited to records of evaluations and/or treatment for alcohol and drug abuse protected under the provisions of Title 42 USCA Section 290dd-3 and 42 CFR Section 2.1 et sec. I understand that this authorization and release permits the State Board of Medical Examiners to receive and examine the records described herein and, if deemed necessary by the Board, to utilize such records in an administrative proceeding instituted by the Board. _____ (Initials)

29. Other requirements: (Include psychotherapy, individual counseling, other treatment, etc., if recommended):

_____(Initials)

Additional Information

Sex: M or F Marital Status: _____ Religious Preference: _____ Race: _____
Name of Spouse: _____
MASA Member: Y or N **Malpractice Carrier**: _____
Alabama License Status: Active Inactive Out of State Retired Unlicensed
Primary Med School Attended: _____ Grad Yr _____
Residency: Specialty: _____ Training Program: _____ Grad Yr _____
Residency: Specialty: _____ Training Program: _____ Grad Yr _____
Residency: Specialty: _____ Training Program: _____ Grad Yr _____
List all States where you have a Medical License: ____ ____ ____ ____ ____ ____ ____ ____
List All Substances abused: Place Asterisk by Drug(s) of Choice: _____ _____ _____
_____ _____ _____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____ _____ _____

Psychiatric Comorbidity: (Dual Diagnoses): _____ _____

We welcome you as an APHP participant.

_____
Signature Date

_____
Printed name

_____
Alabama Physician Health Program Date

_____
Printed name