Monitoring Agreement
(OSBN)

Effective Date: _____

Licensee Name: _____ Date of Birth: _____

The Licensee, in order to remain in compliance with the Health Professionals' Services Program, herein "Program" agrees to the following conditions:

1) I understand that I must comply continuously with this Monitoring Agreement. I understand that the specific number of years will be in my individualized addendum to this Monitoring Agreement. Program is a minimum of four years if referred for substance use or substance use and mental health, and two years if referred for mental health only.

2) I understand that in order to successfully complete the Program, I must have two years of continuous compliance to my monitoring agreement and addendums to my monitoring agreement.

3) I understand that in order to successfully complete the Program, I must have a minimum of two years of monitored practice if I am referred for substance use or substance use and mental health, and one year of monitored practice if I am referred for mental health only. My practice will be monitored throughout my entire program participation whenever I am working in a position that requires my license.

4) I understand that I must comply with any additional rules adopted by my licensing Board regarding participation in the Program and that it is my responsibility to be knowledgeable about these rules. I understand that I may be reported non-compliant if I do not comply with any of my Board specific Program requirements.

5) I understand that I must comply with the Workplace Guidelines for licensees in the Health Professionals' Services Program developed by the Oregon Board of Nursing. The full Workplace Guidelines are attached to this agreement and provide the rationale for and clear work-setting restrictions. Pertinent provisions are excerpted below.

Work-setting restrictions in accordance with the Workplace Guidelines for licensees in HPSP

The Board affirms that direct supervision is required to protect the public and support the licensee. Direct supervision is indicated for all HPSP participants. Direct supervision means a licensee working in the presence of another licensed healthcare professional, functioning at the same or higher level of licensure with relevant clinical competence, who is aware of HPSP participation, is working in the same physical location (e.g. clinic, unit, building), is readily available to observe practice. Therefore the Board has identified certain high-risk settings that will generally be prohibited due to the lack of direct supervision or inconsistent supervisory oversight. These settings include, but are not limited to:

a. Self-employment;
b. Setting owned or managed by a family member;
c. Community-based care (e.g. home health/hospice, assisted living, residential care or foster care facilities, schools);
d. Staffing agency;
e. Float areas outside the participant's workplace monitor's supervised area;
f. Night shifts outside an acute care setting;

6) I agree to remain actively licensed or certified once I am returned to health services practice. I understand that if I allow my license or certification to lapse, I am no longer eligible to be in the Program. I understand that this will be reported to my licensing Board as non-compliance.

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7) If there are limitations on my health profession practice, I agree to practice health professional services within the limitations established by my independent third party evaluator and/or my licensing Board and/or treatment provider. I understand that the specific limitations will be in my individualized addendum to this Monitoring Agreement.

8) I am aware that I may, at the Program's discretion, be required to obtain a third party evaluation of my fitness to practice before the Program removes the limitations on my health profession practice or prior to my graduation.

9) I understand that this Monitoring Agreement may be changed over time as I progress through treatment and the Program, and I agree to execute any addendum to the Monitoring Agreement required by the Program.

10) I will sign all release of information authorizations for the exchange of information between the Program; Board, if Board-referred; monitoring consultants, if I am assigned a monitoring consultant; my employer, if I am employed; third party evaluators and treatment providers and any pertinent family and significant others as requested by the Program. I understand that a refusal to sign a requested release of information may be reported to my licensing Board as non-compliance.

11) I will sign all releases of health information, including, but not limited to, drug, alcohol, and mental health treatment records requested by the Program.

12) I will actively participate in a treatment plan as outlined by a third party evaluator or my current treatment providers and approved by the Program. I understand that simply attending group or therapy sessions does not constitute active participation.

13) If I have a continuing care plan, I will participate in the treatment/continuing care plan as outlined by the independent third party evaluator or treatment provider and approved by the Program. I agree to complete the continuing care plan as described by my specific Program approved caregivers. I will provide the requested documentation from my caregivers to the Program regarding attendance and progress reports on a weekly basis. I understand that a week is from Monday-Sunday and weekly documentation must be received by the Program no later than the close of business on Wednesday of the following week.

    a. I agree to call the Program on a regular basis as stipulated in my individualized addendum to this Monitoring Agreement.

    b. I agree to obtain any medical or psychological testing that may be requested by my caregivers.

14) 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 health profession practice.

15) I will completely abstain from alcohol, marijuana, cocaine, stimulants, narcotics, sedatives, tranquilizers, and all other mind altering and or potentially addicting drugs or medications. I agree to abstain from over-the-counter medications containing alcohol and hemp products and from over-the-counter medications that have stimulating or sedating effects, unless approved by my prescribing physician and food items containing alcohol, poppy seeds, or other substances which may produce a positive test result for drugs or alcohol.

    a. In the event I am prescribed, by a person authorized by law to prescribe the drug for my documented medical condition, a mind altering or intoxicating substance or potentially addictive drug, I will immediately inform the Program and request approval prior to use. I will fax a copy of the prescription to the Program and have the prescriber complete the Medication Management Form.

16) I understand that I must have one prescriber and one pharmacy for all potentially addicting medications. Any extraordinary circumstance must be reviewed and approved by the medical director.

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17) I will report to the Program my use of any mind altering or intoxicating substances or potentially addictive drugs within 24 hours of use. This includes unauthorized or inappropriate use of prescription medications.

18) If applicable, I will under no circumstances write prescriptions for any mind altering or potentially addicting drugs for myself, members of my family, or anyone with whom I do not have an appropriate professional relationship and bona fide medical justification.

19) I will inform my personal physician of the conditions of this Monitoring Agreement and request that he or she not prescribe any mind or mood altering medications for me, unless there is no reasonable alternative. For non-emergent conditions that my physician believes warrants the use of a mind or mood altering substance, I will contact the Program and apply for permission to use the drug in question. I agree to inform the Program 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, unless required due to an extraordinary circumstance.

20) Throughout monitoring, if and when I am employed by a facility or am self-employed, I will identify an appropriate person who could serve as a workplace monitor per the Program established parameters. I will inform this person of my status with the Program and of my need to be in the Program. I will meet with my workplace monitor or supervisor with the frequency determined in my monitoring agreement addendum to document my progress complying with my Monitoring Agreement. I am aware and agree that my workplace monitor will be periodically contacted by the Program and will be asked to provide an assessment of my current ability to comply with this Agreement. Additionally, my workplace monitor will contact the Program in the event my behavior indicates concern. In the event my workplace monitor is no longer able to provide this function for any reason, I will notify the Program within 24 hours of acquiring this knowledge.

21) I will submit to any and all drug and alcohol testing required by the Program. 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 and by 11:59pmPT on the day I am scheduled to test. It is my responsibility to confirm 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 Program's established toxicology and testing policy and procedures. I will be available for toxicology testing six days a week. I will call the Interactive Voice Response system on a daily basis, excluding Sundays and State of Oregon recognized holidays.

    a. I will submit to random urine/blood/sputum/breath/hair testing as requested, and I understand that I am responsible for the cost of the toxicology testing.

    b. I will check the appropriate panel on my Chain of Custody form as directed by the Interactive Voice Response system which I call on a daily basis, excluding Sunday.

22) If I am not currently enrolled in the toxicology program, I am aware that that I am not currently required to participate in the toxicology program. I understand that if requested by the Program, I must agree to toxicology testing and will submit to any and all drug and alcohol testing required by the Program. I understand that testing may or may not 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 Program's established toxicology and testing policy and procedures. I will be available for toxicology testing six days a week. I will call the Interactive Voice Response system on a daily basis, excluding Sunday and State of Oregon recognized holidays.

    a. I will submit to random urine/blood/sputum/breath/hair testing as requested, and I understand that I am responsible for the cost of the toxicology testing.

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b. I will check the appropriate panel on my Chain of Custody form as directed by the Interactive Voice Response system which I call on a daily basis.

23) I understand that if I participate in or should participate in the toxicology testing program, I must share prior to entering the toxicology testing program, any medical problem that may prevent me from giving a urine sample. Otherwise, I understand that a failure to produce the required 45mL of specimen will be reported as a failure to test which is substantial noncompliance and will be reported to my licensing Board by the Program.

24) I understand that if I participate in or should participate in the toxicology testing program, any evidence of a mood altering drug or alcohol in the specimen sample can result in a change in my Monitoring Agreement or a report of substantial noncompliance to my licensing Board. I understand that it is my responsibility to avoid substances that could result in a non-negative toxicology report, e.g. poppy seed bagels, excessive use of alcohol based hand sanitizers.

25) I agree to provide the Program with 14 day notice prior to of 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.

26) I will report any arrest for or conviction of a misdemeanor or felony crime to the Program within three business days after an arrest or a conviction.

27) I understand that if I am a self-referral, I will have to provide an annual criminal background check which will be at my own expense at my anniversary date of entering the program.

28) I will report to the Program any applications for licensure in other states, changes in employment, changes in practice setting, changes in telephone numbers, and changes in residence within three days of said changes. I understand that a change in practice setting and/or employment may require prior approval from the Program and licensing Board, if I am Board referred.

29) If I am in a monitoring group, I will attend the compliance monitoring group as assigned and on a schedule determined by the Program. I will notify the group facilitator and the Program in the event I am unable to attend a given group prior to missing the assigned group. Failure to contact the group facilitator and the Program within 24 hours of missing a group could be interpreted as noncompliance to my Monitoring Agreement.

30) I will pay for the following services: third party evaluations, all treatment received, monitoring group participation, toxicology testing, Safe Practice Investigations (if required), and fitness to practice evaluations. I understand that maintaining a zero balance 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. I understand that if I do not pay my account, I will not be able to continue in the toxicology program and will no longer be monitored. My suspension from toxicology testing and from monitoring will be reported to my licensing Board. If I am employed, I understand that I will be recommended to step down from employment as I will no longer be monitored.

31) I agree to report telephonically to the Program to review and discuss my progress in the Program. In case of problem identification, I agree to follow the direction of the Program and my providers up to and including taking medical leave.

32) I understand that if I am in violation of my Monitoring Agreement, I will be reported to my licensing Board within 24 hours of the violation. I understand that substantial noncompliance with this Monitoring Agreement includes, but is not limited to: engaging in criminal behavior; engaging in conduct that caused injury, death, or harm to the public, including engaging in sexual impropriety with a patient or client; was impaired in a health care setting in course of employment; was not in compliance with the toxicology testing schedule; tested positive for restricted substances on a toxicology screening; violated a restriction on my practice as imposed by the Program or my licensing Board; was referred to HPSP but failed to enroll in HPSP; forged, tampered with, or modified a prescription; violated any rules of

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prescriptive/dispensing authority; violated any provisions of OAR 851-070-0080; violated any terms of the diversion agreement; or failed to complete the monitored practice requirement as stated in OAR 851-070-0090.

33) I agree to return any calls from the Program within 24 hours or respond to any message on the Interactive Voice Response system within 24 hours.

34) If Board referred: I agree to follow any Board imposed restrictions or requirements, including but not limited to, allowing for supervision of my practice if I am in sole practice or if I am not in an employment setting.

I am aware that my Board may not discipline me solely because I self-referred to or participate in the Program; have been diagnosed with a substance abuse disorder; mental health disorder, including, but not limited to, a gambling disorder or both types of diagnoses; or used controlled substances before entry into the Program, if I did not practice while impaired. I understand that failure on my part to complete the Program or to follow the requirements of this Monitoring Agreement will be reported to my licensing Board. I further understand that any substantial noncompliance on my part with the terms of my Consent to Services Enrollment Agreement (if Board referred) or my Enrollment Agreement (if self-referred) or the terms of this Monitoring Agreement will be reported to my licensing Board within one business day of the Program becoming aware of such noncompliance.

I understand that my mental health records and protected health information are protected under the Health Insurance Portability and Accountability Act of 1996.

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, ORS 430.399(5) and ORS 179.505) 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. In the event I am a self-referred participant for substance abuse in the Program and I revoke my Consent to Release, Use, and Exchange of Information form(s), I understand that the Program is required by Oregon Administrative Rule 415-065-0055 to seek a court order authorizing release of alcohol or drug information protected under 42 CFR Part 2 and ORS 179.505. If I am a Board referred participant in the Program due to my abuse of any substance(s) (drugs or alcohol) and I revoke my Consent to Release, Use, and Exchange of Information form, the Program is compelled by ORS 676.190 to remove my name from the list of enrollees who are participating in the Program, which list will be provided to my licensing Board and the Board will know of my non-participation.. If I am either a self or Board referred participant in the Program due to a diagnosis of mental health disorder and I revoke my Consent to Release, Use, and Exchange of Information form, the Program will report such revocation to my licensing Board.

DATED this _____ day of _____, 20_____.

_____
[Signature]

_____
[Printed Name]

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