OKLAHOMA HEALTH PROFESSIONALS PROGRAM

MONITORING AND ASSISTANCE AGREEMENT

INTRODUCTION

Welcome to the Oklahoma Health Professionals Program (OHPP). This program is sponsored by the Oklahoma State Medical Association (OSMA) in cooperation with health professional organizations. The mission of the OHPP is to protect patients by identifying, intervening, rehabilitating, and providing assistance for, physicians and other health professionals impaired by addictive diseases, and/or mental or emotional illness.

This Agreement ("Agreement") is entered into between the Oklahoma Health Professionals Program, hereinafter referred to as "OHPP" and _____, hereinafter referred to as "Participating Professional". The intended purpose of this Agreement is for the Oklahoma Health Professionals Program (OHPP) to provide advocacy for the Participating Professional during the term of this Agreement. In order to assure that such advocacy is appropriate, the provisions contained in this Agreement will serve to aid the Participating Professional in strengthening their personal recovery program and to assure the OHPP Program representatives that a strong recovery program is in place for the Participating Professional.

All records and information maintained by the OHPP are confidential and are not subject to disclosure. By signing and acknowledging, where applicable, this Agreement you acknowledge that the OHPP may need to disclose confidential and privileged information with entities and/or persons providing you with monitoring or treatment services.

I hereby authorize release of information, limited to compliance with OHPP contract, from the OHPP to the appropriate Board, hospital licensing agency and/or insurance carrier as requested for advocacy purposes.

I will inform, if necessary, any authorized person, entity, applicable governing body (including hospitals, physician groups, credentialing agencies, etc.), receiving reports from the OHPP on my behalf, that the OHPP only provides advocacy assistance to the extent of my participation in the OHPP program and does not provide any opinion nor communication as to my qualifications or competence as a medical professional. _____ (Initials)

I acknowledge my understanding that non-compliance with any of the provisions of this OHPP Agreement (and/or future amendments/extensions to it) may be cause for termination of, or amendment to, this Agreement, and may result in formal notification to the appropriate professional licensing board. Further, my signature confirms my consent to, and authorization for, the OHPP's release of such information during the term of this Agreement in the discretion of the OHPP and its agents. I release the OHPP, from all liability and shall hold harmless all employees, monitoring physicians, agents and all others involved in the operation and service of the OHPP for such reporting. _____ (Initials)

TERMS OF AGREEMENT

In consideration of the services that are to be provided by OHPP for the benefit of the Participating Professional, the undersigned agrees to the following:

I, _____, agree to be bound by the terms and conditions provided for in this Agreement. The term of this Agreement shall be for _____ (__) years, beginning from the date of execution provided herein. Participating Professional acknowledges that any amendment or alteration to this Agreement shall be in writing and approved by the OHPP Medical Director or their designee. Participating Professional understands that the failure of the Participating Professional's compliance with the terms of this Agreement may result in a report being made to the appropriate/applicable governing body that regulates the Participating Professionals designation. In the event that the Participating Professional is unable to maintain compliance with any of the provisions provided for in this Agreement, the Participating Professional shall immediately notify the OHPP as provided for in this Agreement. _____ (Initials)

OKLAHOMA HEALTH PROFESSIONALS PROGRAM

MONITORING AND ASSISTANCE AGREEMENT

1. I authorize and give permission for my family/significant other listed below to communicate freely with OHPP as such information related to my recovery and participation with OHPP:

   1) _____ Cell #:_____ Relationship _____

   2) _____ Cell #:_____ Relationship _____

2. I agree to maintain OHPP knowledge of correct and current contact information: _____ (Initials)

   Employment: _____ Work phone: _____

   Home Address: _____ Cell phone: _____

   Email Address: _____ additional phone/contact: _____

   Primary Care Physician (Name, address, phone & fax) _____

   Primary Pharmacy for my medications: (name, phone, fax) _____

3. I will promptly notify OHPP of any change of identified contacts, employment, occupational employment issues, legal charges or arrests of any nature, Professional liability issues or investigations/orders by professional licensing or other professional agency. _____ (Initials)

4. I agree to obtain and maintain participation with a primary care physician(s) who I will advise of my condition (and, if recommended, my agreement with OHPP). I will adhere with any/all treatment recommendations including aftercare, counseling with a therapist (if recommend by a treatment facility or board order) and will request such health providers send quarterly reports/updates regarding such treatments to OHPP. _____ (Initials)

5. I agree to avoid self-treatment. I will allow my primary care physician(s) to inform OHPP of conditions for which l am under treatment including any and all drugs or medications, prescription and over-the-counter, included in the treatment plan. I will also request that drugs of addiction/controlled substances not be prescribed to treat illnesses unless there is no alternative treatment available. I will engage in a complete physical/medical examination unless done within the last year. _____ (Initials)

6. I agree to withdraw from professional practice for evaluation if, in the opinion of the OHPP, an issue develops that indicates such recommended action. I agree to obtain an assessment/reassessment or appropriate therapy/treatment as deemed necessary by OHPP, and shall provide OHPP with written documentation of such test results and assessment recommendations. I am responsible for the financial costs of any/all recommended evaluations, assessments and treatments. _____ (Initials)

7. I understand that it is my responsibility to ensure that OHPP is provided documentation from all treatment providers of service. I will facilitate OHPP's ability to receive quarterly reports/updates from my treatment providers. I understand that lack of such documentation or reports may be noted in compliance notices/advocacy letters that I request be provided to various entities on my behalf. I understand that continued lack of such documentation is considered as noncompliance and may be cause for termination of this Agreement. _____ (Initials)

8. I agree to be appropriately courteous and cooperative in all contacts with the OHPP staff and representatives of OHPP. I agree to return calls and respond to email communications within 24 hours. _____ (Initials)

MONITORING AND ASSISTANCE AGREEMENT

9. I acknowledge understanding that, during the duration of my contractual Agreement with OHPP, the monitoring period may be extended by the OHPP if it has indications from my behaviors that such action is essential for my recovery, patient/public safety, or other reasons that may arise during my participation with OHPP. I also acknowledge understanding that upon completion of the duration of this Agreement, I may voluntarily participate in an OHPP graduate monitoring agreement which will be established at the time of my OHPP Agreement completion with the OHPP Medical Director. _____ (Initials)

10. I agree to be financially responsibility for the OHPP annual administrative fees of $500.00, and agree to payment for all treatments, evaluations, toxicology tests and any other expenditure provided for myself as required for my participation in the OHPP. In the event I should require and receive OHPP financial assistance funds for treatments, evaluations, toxicology tests, or any other services or expenditures paid on my behalf with OHPP financial assistance, I understand and agree to reimburse/repay OHPP for all financial assistance funds provided by OHPP upon termination of this Agreement. In the event that reimbursement/repayment of the OHPP financial assistance funds advanced on behalf of the Participating Provider has not been completed at the time of this Agreement's termination, I acknowledge and agree that at that time I may qualify for a repayment agreement with OHPP. I acknowledge and understand that a repayment agreement is discretionary with the OHPP and non-repayment of such OHPP funds would indicate **non-**compliance with this OHPP agreement and as such, no OHPP advocacy services will be provided me until resolution of repayment of such funds. _____ (Initials)

TREATMENT AND MONITORING

1. **I agree to maintain abstinence from all psychoactive substances, legal or illegal, including alcohol.**____ (Initials) If any mood-altering and/or potentially addictive medications are required, I will notify OHPP, in advance if possible, and provide documentation of the need for the medication (e.g. copy of the prescription or 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 that I will not consume poppy seeds, nor will I use ethyl alcohol in any form (including "alcohol-free" wine or beer, over-the-counter drugs containing alcohol: cough syrup, Nyquil, or other similar drugs or supplements, mouthwash containing alcohol, food containing alcohol (desserts, vanilla extract, etc), communion wine, or in any other form. Additionally, I agree to neither prescribe mood-altering chemicals to my family and to not keep samples of scheduled medications in my home. _____ (Initials)

2. I agree to attend the scheduled *Medical Professional Support Group Meetings* (caduceus) with at least 75% attendance, including at least twice monthly attendance in either Tulsa or Oklahoma City my first year of monitoring, unless otherwise stated. I agree to send in sign-in sheets showing attendance for any sponsored activities including retreats and conferences, as well as 3 other community recovery support meetings weekly. In addition, I agree to obtain a sponsor with at least two years abstinent recovery, with whom he/she will maintain at least weekly contact. _____ (Initials)

3. I agree to participate in a specified urine, blood, and/or body fluid analysis program approved by OHPP. I agree to familiarize myself with food and substances that are known to produce positive screens. I further agree to review ingredients of products for substances that are known to produce positive screens when available. *No poppy seed, alcohol based medication or foods, etc. If you have any questions call OHPP before you take anything.* In the event of incidental contact, results will be considered in the context of all the monitoring procedures described and discussed in this Agreement. I agree to be financially responsible for all related costs associated with this program.
   Frequency of Testing: _____ Times per Year _____Method _____Monitor _____ (Initials)

MONITORING AND ASSISTANCE AGREEMENT

4. I agree to participate in random validated drug screenings as arranged by OHPP and agree to pay associated costs. Should urine drug screens be questionable, consistently diluted, or testing missed, I agree to further testing as determined by the OHPP and will be responsible for any costs associated with such additional testing. _____ (Initials)

The Oklahoma Health Professionals Program (OHPP) has selected Affinity eHealth (Affinity) as your alcohol and/or drug testing service provider. Affinity selects your test dates and will randomly add additional test to fit your required compliance. You are required to check-in five (5) days per week, Monday through Friday, between the hours of 12:30am to 6:00pm CST for your testing notification. You may now choose to either check-in A) by phone or B) via computer.

a. To check-in by phone, dial 1-877-267-4304 and be prepared to enter your 10 digit PIN# (see back of sheet for value), plus month and year of birth (see back of sheet for your 4-digit DOB, then press 1 to Check-In.

b. To check-in via computer online go to https://www .affinityehealth.com/cms4/?ohpp and enter your username and password you created during your activation process. Once logged in, press the Check-In button.

The Affinity Monitoring Interruption feature enables you to request a temporary interruption or suspension in the requirement to test, or a temporary interruption or suspension of the requirement to check-in each day. Valid reason for requesting a temporary interruption or suspension of your monitoring may include activities such as:

a. Short term vacation to locations where phone service is not available, such as a cruise.

b. Medical leave where you will be incapacitate and unable to check in daily or report for testing.

c. Temporary suspension of your occupational or professional license.

If you choose to submit a Monitoring Interruption Request, your compliance manager is notified and will review your justification for the request and the length of time to be covered. They will evaluate the information submitted to evaluate if a temporary interruption or suspension your requirements are warranted. You will be advised if your request will be granted or denied in writing. Until you receive written confirmation that your request will be approved, you should continue to check in and test as scheduled. I agree to submit to Affinity eHealth as my alcohol and/or drug testing service provider and the terms set forth in that agreement. I further agree to be responsible for all financial related costs associated with Affinity's services. _____ (Initials)

5. The Oklahoma Health Professionals Program (OHPP) has selected Soberlink as its alcohol detection monitoring service for your compliance. You will be required to submit Soberlink tests on time twice daily. Failure to submit timely results in non-compliance reports being sent to OHPP. OHPP requires that all Soberlink tests be submitted within the scheduled *one-hour time period* reflected on this report. Please contact the OHPP if you need to make modifications. *Missed and positive tests will jeopardize your compliance standing with OHPP; and, as a result, OHPP is required to report your non-compliance to your licensing board and/or require you to submit to random urine or blood alcohol screenings to verify your compliance.* I agree to submit to Soberlink alcohol detection monitoring services for alcohol testing and complete a Soberlink Participation Agreement Form (Soberlink Agreement). The Soberlink Agreement shall be part of this Agreement and I further agree to be responsible for all financial related costs associated with Soberlink's services. _____(Initials)

MONITORING AND ASSISTANCE AGREEMENT

6. Should any of the above provisions be violated or questionable, urine drug screen result positive, or significant lapse of any aspects of the personal recovery program as outlines herein; I agree to undergo appropriate professional evaluation and/or treatment at a treatment facility recommended by the OHPP Director. _____ (Initials)

7. In consideration of Participating Professional's participation in the OHPP Program and in consideration of the special benefits and advantages for the Participating Professional arising out of his or her participation in the OHPP Program, Participating Professional accepts all of the risks, known or unknown, arising out of his or her participation in the OHPP Program. Participating Professional exempts, releases and agrees to any and all claims for injury, accident, sickness and damages of whatsoever nature which may be sustained in or arising out of Participating Professional participating in the OHPP Program, whether due to negligence (including gross negligence) of OHPP, Oklahoma State Medical Association (OSMA) or its employees or agents while Participating Professional is participating in the OHPP Program. _____ (Initials)

8. Participating Professional, recognizing his or her voluntary participation in the OHPP Program, releases OSMA, OHPP or its employees or agents from any claim for any damages or injury whatsoever. The Participating Professional agrees to protect, indemnify and hold harmless OHPP and OSMA from any and all sums that OHPP and OSMA may become subject to, as a consequence of any claim in the future due or growing out of any claim or injury arising out of Participating Professional's participation in the OHPP Program, brought by Participating Professional, his or her heirs, executors and assigns. _____ (Initials)

9. Participating Professional agrees to an exit interview upon completion of the contract period, and will consider participating in an OHPP graduate monitoring agreement upon successful completion of contract period. Should any of these provisions be violated or be questionable, urine drug screen test be positive, or should there be a significant lapse of any of the other aspects of the personal recovery program as outlined herein, advocacy will not be given and the appropriate Board, hospital, licensing agency or insurance carrier may be notified immediately. Participant agrees to undergo appropriate evaluation and/or treatment at a treatment facility recommended by OHPP. _____ (Initials)

Executed this ____ day of _____, 20__.

_____ _____

Program Participant OHPP Medical Director

Last Name:_____First Name:_____Middle Initial:_____DOB:_____