

Provisional Enrollment Agreement [Self-Referred]

MONITORING

By signing this Provisional Enrollment Agreement (“Agreement”) you are not enrolled in the **Health Professionals’ Services Program** (“Program”) until all the following actions have been taken or completed:

1. You must state that, to the best of your knowledge and belief, you are not currently under investigation by the _____ (“Board”). By signing this Agreement, you shall be considered to be attesting to such fact.
2. **For OSBN licensees only:** You must state that, to the best of your knowledge and belief, you have not violated the Nurse Practice Act. By signing this Agreement, you shall be considered to be attesting to such fact.
3. You must be evaluated, at your expense, by a Board-approved third party evaluator within 10 days of signing this Agreement. The Program may, in its sole discretion, extend the time for such evaluation if circumstances warrant.
4. By signing this Agreement, you are agreeing to sign two separate Consent documents which will permit the following:
 - a. disclosures and exchanges of confidential information (including, but not limited to protected health information, drug, alcohol and/or mental health treatment records and your participation in the Program) to and between Program, monitoring consultants, if necessary or appropriate your employer, independent third party evaluators (Board-approved) and your treatment providers; or
 - b. disclosures and exchanges of confidential information between the Program, your Board, your Board-approved independent third party evaluator, your treatment provider and, if appropriate, your employer, of either your substantial noncompliance with the terms of your Monitoring Agreement and any addenda thereto or your failure to complete your enrollment in the Program after you have signed this Agreement or for OSBN licensees, if in the course of conducting the safe practice investigation, it is reported to the investigator that you have violated the Nurse Practice Act.
4. You must sign both a Monitoring Agreement and, upon your successful fulfillment of the conditions set forth therein, a Monitoring Agreement Addendum.
5. You must cooperate with the Program’s fitness for safe practice investigation to determine whether your practice while impaired presents or has presented a danger to the public. This must commence within 20 business days after the Consent to Release, Use and Exchange Information #1 has been received by Integrated Behavioral Health. Failure to cooperate will be considered evidence of failure to enroll.
6. You are agreeing to sign an Amended Monitoring Agreement(s) if, in the sole discretion of the Program, such Amended Agreement is necessary or appropriate for you to remain a self-referred participant in the Program.
7. As a condition of your provisional enrollment, you must cease all health care practice(s) permitted under your license(s) until the completion of the independent third party evaluation and safe practice investigation. Workplace limitations, if appropriate, will be determined following the recommendations of the third party evaluator and care providers. If you sign this Provisional Agreement and thereafter refuse to immediately cease your current practice during the assessment process or at any other time the Program so requests, you will be reported to your licensing Board.

NOTE: (1) After signing this Agreement, if you fail to obtain the independent third party evaluation, fail to cooperate with the Program’s fitness for safe practice evaluation, fail to sign the Consents noted in Paragraph 3 above, fail to sign an Authorization to Use and Disclose Protected Health Information - including mental health treatment records, fail to sign the Provisional Monitoring Agreement or the Monitoring Agreement, you understand and agree that you will be reported to your licensing Board.

(2) If I have self-referred for abuse of any substance(s) (drugs and alcohol), and I revoke my Consent to Release, Use and Exchange of Information which, among other things, allows disclosure of my confidential alcohol and drug treatment records; or, if I revoke my Authorization to Use and Disclose Protected Health Information, I agree that such act(s) shall constitute my voluntary disenrollment from the Program. I understand that under such circumstances, 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.

(3) If my enrollment in the Program was due to a diagnosis of a mental health disorder, I agree that if I revoke my Consent to Release, Use and Exchange of Information form which, among other things, allows disclosure of my mental health treatment records, or if I revoke my Authorization to Use and Disclose Protected Health Information - including mental health treatment records, such act(s) will constitute my voluntary disenrollment from the Program. I understand that under such circumstances, the Program is compelled by ORS 676.190 and associated Administrative Rules to report my disenrollment to my licensing Board.

I agree to all of the above conditions and terms and attest this _____ day of _____, 20____ that to the best of my knowledge and belief that I am not currently under investigation by my Board.

[Signature]

[Printed Name]

YOU ARE NOW PROVISIONALLY ENROLLED

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.

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