

Massachusetts Department of Public Health
Bureau of Substance Addiction Services
KEY PERSONNEL CHANGE REPORTING FORM

Please fax the completed form (no cover sheet is necessary) to the secure eFax: 617-887-8787

Instructions:

- Per 105 CMR 164.000 please notify DPH/BSAS **at least 14 calendar days prior to** a planned change or **the next business day** for an unplanned change.
- Attach a **resume & copy of credentials** of the replacement and **interim coverage plan addendum** as needed.
- Indicate **all BSAS license and approval numbers** impacted by the key personnel change.

License(s)/ Approval(s) #:	Date of Report:
Agency Name:	Program Name:
Program Address:	
Reporter Name & Title:	Reporter Contact:

Outgoing Staff Information

Outgoing Staff Name:

Last Day:

Outgoing Staff Role

- | | | |
|--|---|--|
| <input type="checkbox"/> Program Director | <input type="checkbox"/> Clinical Supervisor/ Clinical Director | <input type="checkbox"/> Medical Director |
| <input type="checkbox"/> Nursing Director | <input type="checkbox"/> Executive Director | <input type="checkbox"/> President/Chairperson |
| <input type="checkbox"/> Access Coordinator | <input type="checkbox"/> HIV/AIDS Coordinator | <input type="checkbox"/> Tobacco Education Coordinator |
| <input type="checkbox"/> License Administrator | <input type="checkbox"/> VG Administrator | |

Incoming Staff Information

- ☐ Permanent ☐ Interim (if interim, you must complete the interim coverage plan addendum)

Incoming Staff Name:

Start Date:

Email Address:

Phone Number:

Incoming Staff Role

- | | | |
|--|---|--|
| <input type="checkbox"/> Program Director | <input type="checkbox"/> Clinical Supervisor/ Clinical Director | <input type="checkbox"/> Medical Director |
| <input type="checkbox"/> Nursing Director | <input type="checkbox"/> Executive Director | <input type="checkbox"/> President/Chairperson |
| <input type="checkbox"/> Access Coordinator | <input type="checkbox"/> HIV/AIDS Coordinator | <input type="checkbox"/> Tobacco Education Coordinator |
| <input type="checkbox"/> License Administrator | <input type="checkbox"/> VG Administrator | |

Optional Section – Reason for Staff Departure:

- | | |
|--|---|
| <input type="checkbox"/> Internal Promotional Opportunity | <input type="checkbox"/> Interim Backfill |
| <input type="checkbox"/> Result of staff misconduct/ administrative action | <input type="checkbox"/> Hired Elsewhere (private practice, other agency, government, etc.) |
| <input type="checkbox"/> Left SUD Treatment Field | <input type="checkbox"/> Other |

Massachusetts Department of Public Health
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KEY PERSONNEL CHANGE REPORTING FORM – Interim Coverage Plan Addendum
Please fax the completed form (no cover sheet is necessary) to the secure eFax: 617-887-8787

Instructions: Please describe the anticipated coverage timeline including who(m) will be providing the interim coverage, what roles the person(s) involved currently hold, and if they are providing interim coverage in any other role or program. Explain how this person(s) meets the regulatory criteria required for the role (if any). How will the program ensure that the person(s) providing interim coverage are oriented to the responsibilities of this role? Please provide the program’s plan to recruit and fill the role on a permanent basis.

Should you need additional space to answer any questions you may add an additional page to provide your response or to provide any additional relevant information regarding your interim coverage plan to BSAS.

All interim coverage plans are subject to review by BSAS. BSAS may, at its discretion, request additional information, request that the provider complete a regulatory waiver application, or determine that an interim coverage plan is insufficient.

Please contact your Regional Licensing Inspector with any follow-up questions.

Program Response: