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APPLICATION FOR ADMISSION INTO THE  
PHARMACY SUBSTANCE USE DISORDER REHABILITATION PROGRAM (PSUD)

Please read and initial the following statements.

Application

- \_\_\_\_\_ I have read through these statements prior to completing and submitting this application.
- \_\_\_\_\_ I understand that PSUD is a program offered by the Massachusetts Board of Registration in Pharmacy (Board) pursuant to M.G.L. c. 112, § 24H for registered pharmacists, pharmacy interns and pharmacy technicians who have a substance use issue necessitating rehabilitation.
- \_\_\_\_\_ I have a substance use issue and I am applying to participate in PSUD because I am seeking rehabilitation.
- \_\_\_\_\_ I understand that PSUD is not a treatment program, but a program that provides participants with an Individualized Rehabilitation Plan (IRP) and monitors their compliance with that IRP.
- \_\_\_\_\_ I have had an opportunity to discuss the PSUD program and this application with a PSUD Supervisor.

PSUD Rehabilitation Evaluation Committee and PSUD Supervisor

- \_\_\_\_\_ I understand that the PSUD Rehabilitation Evaluation Committee (REC) is a team of individuals who meet criteria set by law that have been appointed by the Board to evaluate my application to participate in PSUD and to make recommendations for my IRP, both at the beginning of my participation and during the course of my participation based on my compliance and progress.
- \_\_\_\_\_ I understand that the PSUD Supervisor is a member of the Board's staff who acts as liaison between me, Board members and the REC.
- \_\_\_\_\_ I understand that I need to meet with the REC prior to my admission into the Program.
- \_\_\_\_\_ I understand that the REC will review the information provided in or with this application, and that the REC may ask additional questions about this information.

Confidentiality and License Status– Application phase

- \_\_\_\_\_ I understand and **agree** that upon receipt of my application, the Board will change my license status to non-disciplinary restriction, which is a license status in which I will not be permitted to practice.
- \_\_\_\_\_ I understand that the fact of the non-disciplinary restriction *license status* will be public, but the reason for such status will not be disclosed.
- \_\_\_\_\_ I understand that if I am admitted into PSUD, the fact of my *application* to PSUD and the information provided in or with my application will be confidential.
- \_\_\_\_\_ I understand that if I decide not to participate in PSUD after I have submitted this application, the information provided in or with this application may be used by the Board in connection with a disciplinary action against my license.

\_\_\_\_\_ I understand that to the extent that information provided in or with this application is exempt from disclosure under public records law, it will not be made a public record even if it is used by the Board in connection with a disciplinary action against my license.

#### Confidentiality– Participation phase

\_\_\_\_\_ I understand that while I participate in PSUD, the Board will keep my license status as non-disciplinary restriction until such time as my IRP is changed to allow me to return to practice, which will be based on my compliance and progress. When my IRP is changed to allow practice, my license status will be changed to non-disciplinary conditions.

\_\_\_\_\_ I understand that the fact of the non-disciplinary restriction or non-disciplinary conditions license status will be public, but the reason for such status will not be disclosed.

\_\_\_\_\_ I understand that while I participate in PSUD, the information provided in or with my application, to the REC and to the PSUD Supervisor, and the information gathered by the PSUD Supervisor as part of monitoring my progress will be confidential.

#### Agreement with the Board and Alternative to Discipline

\_\_\_\_\_ I understand that in order to participate in PSUD, I need to enter into an agreement with the Board and that the agreement will incorporate and require compliance with my IRP.

\_\_\_\_\_ I understand that the Board has established standard provisions for IRPs and that these may be tailored, per the REC's recommendations, to my circumstances, both at the start of my participation and during the course of my participation based on my compliance and progress.

\_\_\_\_\_ I understand that the "alternative to discipline" means that as part of the agreement, the Board will dismiss any complaints pending against my license that are related to or attributable to my substance use disorder and that the reason for the dismissal will not be disclosed.

\_\_\_\_\_ I understand that I may my participation in PSUD may be terminated, by the Board or by the PSUD Supervisor, based on lack of compliance with my IRP, the agreement, or a subsequent complaint against my license as set forth in the agreement.

\_\_\_\_\_ I understand that I may dispute the issue of whether I have failed to comply with my IRP and request a hearing before the Board limited to that issue, and that in such a hearing, the Board may use the information provided in or with my application, to the REC and to the PSUD Supervisor, and the information gathered by the PSUD Supervisor as part of monitoring my progress.

\_\_\_\_\_ I understand that to the extent that information provided in or with this application to the REC and to the PSUD Supervisor, and the information gathered by the PSUD Supervisor as part of monitoring my progress, is exempt from disclosure under public records law, it will not be made a public record even if it is used by the Board in connection with a disciplinary action against my license.

\_\_\_\_\_ I understand that as part of the agreement, the Board may take disciplinary action against my license on the basis of my withdrawal from PSUD, or the termination of my participation in PSUD.

#### Costs

\_\_\_\_\_ I understand that there are costs involved with participating in PSUD, including but not limited to the costs of random urine testing and costs related to counseling and therapy.

\_\_\_\_\_ I understand that I am responsible for all costs associated with participation in PSUD.

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

APPLICANT'S INITIALS: \_\_\_\_\_

## APPLICANT:

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ AGE: \_\_\_\_\_

CONTACT INFO: HOME: \_\_\_\_\_ CELL: \_\_\_\_\_  
WORK: \_\_\_\_\_ EMAIL: \_\_\_\_\_

### REFERRAL SOURCE (check all that apply):

- ☐ Self    ☐ PSUD Supervisor    ☐ Board Member(s)    ☐ Board Staff    ☐ DPH Investigator  
☐ Employer    ☐ EAP    ☐ Peer    ☐ Treatment Provider    ☐ Police  
☐ Family    ☐ Lawyer    ☐ Other: \_\_\_\_\_

### MASSACHUSETTS BOARD OF REGISTRATION IN PHARMACY LICENCURE:

- ☐ Pharmacist    ☐ Pharmacy Intern    ☐ Pharmacy Technician

LIC#: \_\_\_\_\_ License Exp. Date: \_\_\_\_\_

Is there an open investigation or complaint against this license?    ☐ Yes    ☐ No

If yes, Investigation/Docket No. \_\_\_\_\_

### OTHER PROFESSIONAL REGISTRATIONS

Please attach a separate sheet if necessary.

<i>state</i>	<i>license &amp; license #</i>	<i>license status</i>

## EMPLOYMENT

### CURRENT EMPLOYMENT STATUS

(check all that apply)

- ☐ Employed outside of Profession: \_\_\_\_\_  
☐ Employed in Profession – Employer is ☐ aware of    ☐ unaware of substance use disorder  
☐ Unemployed since \_\_\_\_\_  
☐ On Leave:    ☐ Medical Leave    ☐ Disability Leave    ☐ Administrative Leave  
☐ Other: \_\_\_\_\_

**CURRENT EMPLOYMENT**

Please attach a separate sheet if necessary.

<i><b>position held</b></i>	<i><b>employer (include supervisor name &amp; #)</b></i>	<i><b>hours/week</b></i>	<i><b>years in position</b></i>

Are there any special practice provisions in place in your current employment? ☐ Yes ☐ No  
(If "yes", please specify)

**PREVIOUS EMPLOYMENT HISTORY**

Please attach a separate sheet if necessary.

<i><b>position held</b></i>	<i><b>employer</b></i>	<i><b>years in position</b></i>	<i><b>reason for separation</b></i>
			<input type="checkbox"/> Terminated <input type="checkbox"/> Resigned/Quit <input type="checkbox"/> Other Reason:
			<input type="checkbox"/> Terminated <input type="checkbox"/> Resigned/Quit <input type="checkbox"/> Other Reason:
			<input type="checkbox"/> Terminated <input type="checkbox"/> Resigned/Quit <input type="checkbox"/> Other Reason:
			<input type="checkbox"/> Terminated <input type="checkbox"/> Resigned/Quit <input type="checkbox"/> Other Reason:

## MEDICAL AND MENTAL HEALTH HISTORY

### MEDICAL HEALTH HISTORY

Please describe significant past and present non-psychiatric medical problems including work-related injuries, chronic illnesses/disorders and surgeries. Please attach a separate sheet if necessary.

<i>medical health problem</i>	<i>current/historic</i>	<i>diagnosis date</i>	<i>treatment</i>

### CURRENT MEDICAL TREATMENT PROVIDERS

<i>provider name</i>	<i>specialty</i>	<i>last visit</i>	<i>address / contact information</i>
	Primary Care Provider		

Have you had a physical examination within the past year? ☐ Yes ☐ No

If yes, name of provider: \_\_\_\_\_ Date: \_\_\_\_\_

If no, are you willing to obtain one within the next thirty (30) days? ☐ Yes ☐ No

### MENTAL HEALTH HISTORY

Please describe significant past and present psychiatric/mental health problems. Please **do not** include any problem or treatment that was only related to drug or alcohol use in this section. Please attach a separate sheet if necessary.

<i>mental health problem</i>	<i>current/historic</i>	<i>diagnosis date</i>	<i>treatment</i>

### CURRENT MENTAL HEALTH TREATMENT PROVIDERS

<i>provider name</i>	<i>specialty</i>	<i>last visit</i>	<i>address / contact information</i>

## CURRENT MEDICATIONS

Please identify the medications you are currently prescribed as well as commonly used over-the-counter drugs. Attach a separate sheet as necessary.

<i>medication</i>	<i>presenting symptom</i>	<i>date first prescribed</i>	<i>dosage &amp; frequency</i>	<i>prescriber</i>

*For the following questions, if answering yes please describe on line provided or attach a separate sheet as necessary:*

Have you ever experienced depression? ☐ Yes ☐ No

Have you ever been treated for anxiety? ☐ Yes ☐ No

Have you ever experienced panic attacks? ☐ Yes ☐ No

Have you attempted or thought about suicide? ☐ Yes ☐ No

Have you ever had a psychiatric hospitalization? ☐ Yes ☐ No

Has anyone close to you died recently or in the past that has been difficult to grieve? ☐ Yes ☐ No

Have you experienced any other difficult losses? ☐ Yes ☐ No

Have you ever experienced memory loss? ☐ Yes ☐ No

Have you ever experienced flashbacks? ☐ Yes ☐ No

Have you ever experienced nightmares? ☐ Yes ☐ No

Have you ever experienced sexual assault? ☐ Yes ☐ No

Have you ever experienced domestic violence? ☐ Yes ☐ No

Have you ever experienced a hate crime? ☐ Yes ☐ No

## ALCOHOL/DRUG USE HISTORY

Do you have or have you ever had a problem with alcohol or drugs?

☐ Yes ☐ No ☐ Unsure

➔ Please explain in detail

This image shows a single sheet of white paper with horizontal blue ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Describe your current work or most recent work setting in relation to your drug or alcohol use. Include information on ease of access to drugs, type of structure within the environment, amount and type of supervision available, general environment, and availability of employee assistance personnel.

[illegible]

**ADDICTIVE BEHAVIOR IDENTIFICATION**

(check all which you currently feel apply to you)

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Substance Use Disorder | <input type="checkbox"/> Chemically Dependent  | <input type="checkbox"/> Drug Addict     | <input type="checkbox"/> Problem Drinker        |
| <input type="checkbox"/> Poly-Substance User    | <input type="checkbox"/> Nicotine Addiction    | <input type="checkbox"/> Alcoholic       | <input type="checkbox"/> Caffeine Addiction     |
| <input type="checkbox"/> Gambling Addict        | <input type="checkbox"/> Food Addict/Overeater | <input type="checkbox"/> Spending Addict | <input type="checkbox"/> Work Addict/Workaholic |
| <input type="checkbox"/> Sex/Intimacy Addict    | <input type="checkbox"/> Other: _____          |  |   |

**USE SUMMARY**

<b><i>when was your First ...</i></b>	<b><i>age</i></b>	<b><i>place/setting</i></b>
<i>drink (specify):</i>		
<i>drug (specify):</i>		
<i>tobacco (specify):</i>		

<b><i>when was your Last ...</i></b>	<b><i>date</i></b>	<b><i>place/setting</i></b>
<i>drink (specify):</i>		
<i>drug (specify):</i>		
<i>tobacco (specify):</i>		

Please identify your drugs of choice (including alcohol) in order of preference:

<b><i>preference</i></b>	<b><i>drugs of choice</i></b>
#1	
#2	
#3	
#4	
#5	

Have you ever used drugs intramuscularly/intravenously?

☐ Yes ☐ No

➔ If yes, have you ever shared needles?

☐ Yes ☐ NoHave you been tested for hepatitis/HIV? ☐ Yes ☐ No

If yes, when was your most recent test \_\_\_\_\_

Please check all the boxes that you feel accurately complete this sentence: **"I use or have used drugs or alcohol to ..."**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> feel more confident    | <input type="checkbox"/> relax                  | <input type="checkbox"/> function better at my job             |
| <input type="checkbox"/> have more energy       | <input type="checkbox"/> feel more comfortable  | <input type="checkbox"/> sleep                                 |
| <input type="checkbox"/> get through the day    | <input type="checkbox"/> feel numbed out        | <input type="checkbox"/> talk to other people more easily      |
| <input type="checkbox"/> overcome physical pain | <input type="checkbox"/> overcome loneliness    | <input type="checkbox"/> overcome emotional/psychological pain |
| <input type="checkbox"/> forget things          | <input type="checkbox"/> other (specify): _____ |  |

Have you ever used alcohol or drugs to relieve tension or forget problems? ☐ Yes ☐ No

Have you ever experienced an increase in tolerance with your alcohol and/or drug use? ☐ Yes ☐ No

Have you ever experienced a decrease in tolerance or that you can't use as much as you used to? ☐ Yes ☐ No

Have you ever tried to hide your alcohol or drug use? ☐ Yes ☐ No

Have you ever drank alcohol or used drugs more than you had intended? ☐ Yes ☐ No

Have you ever felt uncomfortable when alcohol or drugs are not available? ☐ Yes ☐ No

Have you ever felt guilty about your alcohol or drug use? ☐ Yes ☐ No

Have you ever felt irritated when your drinking or drug use is discussed? ☐ Yes ☐ No

Have you ever continued drinking or drug use after others stopped? ☐ Yes ☐ No

Have you ever had financial difficulties due to spending a lot of money on alcohol or drugs? ☐ Yes ☐ No

Have you ever experienced blackouts or memory lapses while using alcohol or drugs? ☐ Yes ☐ No

Have you ever done anything while using alcohol or drugs which you would not have done if sober? ☐ Yes ☐ No

Do you believe that you have ever been preoccupied or obsessed with drinking or using drugs? ☐ Yes ☐ No

Have you looked forward to drinking or using drugs? ☐ Yes ☐ No

Have people close to you ever complained of your drinking or drug use? ☐ Yes ☐ No

Has your significant other ever felt you have a problem with drugs or alcohol? ☐ Yes ☐ No ☐ n/a

Does your significant other know about your current or past drug or alcohol problem? ☐ Yes ☐ No ☐ n/a

Have other family members or friends ever expressed any concern about your alcohol or drug use? ☐ Yes ☐ No ☐ n/a

Is your significant other aware of your current difficulties? ☐ Yes ☐ No ☐ n/a

Does your significant other know about your referral and application for SARP admission? ☐ Yes ☐ No ☐ n/a

Has your alcohol or drug use ever affected your job? (i.e. termination, demotion, etc.) ☐ Yes ☐ No

➔ Describe: \_\_\_\_\_

Has your alcohol or drug use ever affected your health? ☐ Yes ☐ No

➔ Describe: \_\_\_\_\_

Have you ever abused prescription drugs? ☐ Yes ☐ No

➔ Describe: \_\_\_\_\_

Do you abuse or have ever abused more than one drug at a time? ☐ Yes ☐ No

➔ Describe: \_\_\_\_\_

Have you ever engaged in illegal activities in order to obtain drugs? ☐ Yes ☐ No

➔ Describe: \_\_\_\_\_

Do you use or have you used alcohol or drugs on a daily or continuous basis? ☐ Yes ☐ No

➔ Describe: \_\_\_\_\_

On a scale from 1 to 5, how severe do you think your alcohol and/or drug problem is? (Circle a number.)

**Not Severe   1   2   3   4   5   Very Severe**

Please explain the events that lead to your referral to the PSUD program.

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Have you ever made any conscious attempt(s) to stop your alcohol/drug use? ☐ Yes ☐ No  
If yes, please identify below.

<i><b>date of attempt</b></i>	<i><b>method/significant information</b></i>	<i><b>length of sobriety</b></i>

### WITHDRAWAL/DETOXICATION HISTORY

Have you ever experienced any of the following signs/symptoms during any alcohol or drug withdrawal.

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Elevated BP        | <input type="checkbox"/> Anhedonia               | <input type="checkbox"/> Tachycardia     | <input type="checkbox"/> Dizziness/light-headedness |
| <input type="checkbox"/> Flushing           | <input type="checkbox"/> Hyperventilation        | <input type="checkbox"/> Shakes/tremors  | <input type="checkbox"/> Lowered blood pressure     |
| <input type="checkbox"/> Convulsions        | <input type="checkbox"/> Depression              | <input type="checkbox"/> Nausea          | <input type="checkbox"/> Drug hunger/cravings       |
| <input type="checkbox"/> Vomiting           | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Hyperactivity/restlessness |
| <input type="checkbox"/> Diaphoresis        | <input type="checkbox"/> Irritability            | <input type="checkbox"/> Blackouts       | <input type="checkbox"/> Hallucinations (Tactile)   |
| <input type="checkbox"/> Mood swings        | <input type="checkbox"/> Cold sweats             | <input type="checkbox"/> Bond/joint pain | <input type="checkbox"/> Hallucinations (Auditory)  |
| <input type="checkbox"/> Disorientation     | <input type="checkbox"/> Sleeplessness           | <input type="checkbox"/> Visual          | <input type="checkbox"/> Hallucinations (Visual)    |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Muscle aches/pain       | <input type="checkbox"/> "Goose flesh"   | <input type="checkbox"/> Hallucinations (Olfactory) |
| <input type="checkbox"/> Abdominal cramps   | <input type="checkbox"/> Other (describe): _____ |  |   |

### INVOLVEMENT IN RECOVERY GROUPS

Please describe your historic & current involvement with the self-help groups below. Please note "N/A" if appropriate.

<b><i>self-help group</i></b>	<b><i>involvement (past and current)</i></b>	<b><i>currently attend</i></b>
Alcoholics Anonymous		# of mtgs/week:
Narcotics Anonymous		# of mtgs/week:
Professional Support		# of mtgs/week:
A Way of Life (AWOL)		# of mtgs/week:
SMART Recovery		# of mtgs/week:
Moderation Management		# of mtgs/week:
Other:		# of mtgs/week:

Do you have a sponsor? ☐ No ☐ Yes, first name: \_\_\_\_\_ Frequency of Contact: ☐ daily ☐ weekly ☐ monthly

Do you have a home group? ☐ Yes ☐ No Location & name of group: \_\_\_\_\_

How often do you attend the following kinds of meetings? (Please provide number of meetings per week.)

☐ Big Book mtgs: \_\_\_\_ ☐ Discussion mtgs: \_\_\_\_ ☐ Step mtgs: \_\_\_\_ ☐ Other: \_\_\_\_\_

### PAST DRUG/ALCOHOL TREATMENT

Please identify the forms of treatment you'd have related to your drug or alcohol use.

Have you ever entered a detoxification program? ☐ Yes (please identify below) ☐ No

<b><i>date entered</i></b>	<b><i>program name &amp; location</i></b>	<b><i>length of treatment</i></b>


Have you ever entered an in-patient program? ☐ Yes (please identify below) ☐ No

<i><b>date entered</b></i>	<i><b>program name &amp; location</b></i>	<i><b>length of treatment</b></i>

Have you ever entered an intensive outpatient program? ☐ Yes (please identify below) ☐ No

<i><b>date entered</b></i>	<i><b>program name &amp; location</b></i>	<i><b>length of treatment</b></i>

Have you ever entered a halfway house or transitional living program? ☐ Yes (please identify below) ☐ No

<i><b>date entered</b></i>	<i><b>program name &amp; location</b></i>	<i><b>length of treatment</b></i>

Have you ever entered outpatient counseling or group counseling? ☐ Yes (please identify below) ☐ No

<i><b>date entered</b></i>	<i><b>program name &amp; location</b></i>	<i><b>length of treatment</b></i>

## **PAST/PRESENT LEGAL HISTORY**

Please describe the charges and disposition of any legal matters you are involved with.

Have you ever been arrested?

☐ Yes ☐ No

→ Describe: \_\_\_\_\_

Have you ever been arrested while under the influence of drugs or alcohol?

☐ Yes ☐ No

→ Describe: \_\_\_\_\_

Have you ever been arrested for possession or distribution of any controlled substances?

☐ Yes ☐ No

→ Describe: \_\_\_\_\_

Have you ever been incarcerated? If yes, please include time served.

☐ Yes ☐ No

→ Describe: \_\_\_\_\_

Do you currently have a parole or probation officer? ☐ No ☐ Yes

→ If yes, officer's name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Will the officer be requiring communication with PSUD? If so, please describe: \_\_\_\_\_

Do you currently have a lawyer? ☐ No ☐ Yes

→ If yes, lawyer's name: \_\_\_\_\_ Phone number: \_\_\_\_\_

## **FINANCIAL CONCERNS**

Please describe any current financial problems or constraints.

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## **SOCIAL/FAMILY HISTORY**

Has anyone in your family ever had an alcohol and/or drug problem? ☐ No ☐ Yes If yes, please check off all those below.

### Immediate Family

☐ Parent(s)

☐ Sibling(s)

☐ Other: \_\_\_\_\_

### Partner's Family

☐ Partner's Parent(s)

☐ Partner's Sibling(s)

☐ Other: \_\_\_\_\_

### Paternal Family

☐ Grandparent(s)

☐ Aunt/Uncle(s)

☐ Other: \_\_\_\_\_

### Maternal Family

☐ Grandparent(s)

☐ Aunt/Uncle(s)

☐ Other: \_\_\_\_\_

### Other Family

☐ Other: \_\_\_\_\_

☐ Other: \_\_\_\_\_

☐ Other: \_\_\_\_\_

Are you currently in a relationship? ☐ Yes ☐ No

➔ If yes, length of relationship: \_\_\_\_\_

Is your partner supportive of your recovery? Please describe: \_\_\_\_\_

*For the following questions, if answering yes please describe on line provided or attach a separate sheet as necessary:*

Has your partner physically struck/kicked you? ☐ Yes ☐ No

Does your partner ever act controlling/jealous? ☐ Yes ☐ No

Do you feel unsafe in your current relationship? ☐ Yes ☐ No

Do you feel unsafe from a past relationship now? ☐ Yes ☐ No

**CHILDREN (from oldest to youngest)**

<b>age</b>	<b>custody/living situation</b>

Check any of following people who know about your current problem:

Family

- ☐ Partner(s) ☐ Parent(s)  
☐ Child(ren) ☐ Grandparent(s)  
☐ Sibling(s) ☐ Aunt/Uncle(s)  
☐ Partner's Sibling(s) ☐ Partner's Parent(s)  
☐ Other: \_\_\_\_\_

Other

- ☐ Co-workers ☐ Boss  
☐ Self-Help Group ☐ Colleagues  
☐ Friends ☐ Religious community  
☐ Other: \_\_\_\_\_

Describe your current support system (who in your life is supportive and knows about your alcohol or/and drug problem):

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