The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
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SUPERVISOR VERIFICATION AND AGREEMENT TO MONITOR PRACTICE AND PROVIDE PERIODIC REPORTS TO THE BOARD OF PHARMACY

Date:

Dear Massachusetts Board of Registration in Pharmacy:

This is to confirm that _____ has informed me that he/she is a participant in the Pharmacy Substance Abuse Rehabilitation Program (PSUD), and has provided me with a copy of her current PSUD Consent Agreement for PSUD Participation.

I understand I am agreeing to:

- submit to PSUD a Pharmacy Supervisor Report of this pharmacy clinician
- honor the practice restrictions of the pharmacy clinician as detailed in the PSUD Participation Agreement.

I understand the pharmacy clinician is monitored by random supervised urine toxicology screens and if any results are positive, I will be notified. In the event of a positive result, I understand that the pharmacy clinician may be temporarily removed from practice until a full PSUD evaluation is completed.

I understand the goal of PSUD is to provide the pharmacy clinician with an opportunity to engage in sustained recovery while demonstrating safe pharmacy practice.

I further certify that I am a Pharmacist, have completed at least one (1) year of clinical pharmacy practice, and that I do not have any open administrative or criminal complaint, or any current license discipline by any Board of Pharmacy.

_____ _____
Supervisor Name (print) Title of Supervisor

_____
Supervisor Signature and Date

_____
Employer Name

_____
Address

_____

_____ _____
City State Zip Telephone Number