The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
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Pharmacy Substance Use Disorder (PSUD) Program

MONITORING COVER SHEET

Name of PSUD Participant: _____

Phone Number: _____

Pharmacy License Number: _____

Monitoring Meeting Date: _____

Monitoring Forms Submitted:

- ☐ Self-Report
- ☐ Professional Support Group Evaluation
- ☐ Individual Therapy Evaluation
- ☐ Meeting List
- ☐ Job Performance Evaluation
- ☐ Medication List
- ☐ Contract Change Form