The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
250 Washington Street, Boston, MA 02108-4619

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Pharmacy Substance Use Disorder (PSUD) Program

Request for Treatment Contract Change

Date of original treatment contract signed by the coordinator: _____

Proposed treatment contract change:

change from:	change to:

Rationale for Change(s):

Please describe the progress in your recovery that supports this change:

Please forward your therapist and/or employer's recommendations to us regarding the requested change, when appropriate.

Therapist recommendation included: ☐ yes ☐ no to be forwarded: ☐ yes ☐ no
Employer recommendation included: ☐ yes ☐ no to be forwarded: ☐ yes ☐ no

_____ _____
Licensee signature Date

For PSUD Committee Only:

Date received: _____ Decision date: _____

Approved ☐
Denied ☐

Comments: