



The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Department of Public Health  
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**SARP: CASP AMENDMENT REQUEST FORM**

Name of SARP Participant (please print): \_\_\_\_\_

Effective Date of Consent Agreement for SARP Participation (CASP): \_\_\_\_\_

Amendment for Nursing Privileges		Select One	Key
<input type="checkbox"/> From No Nursing Practice to: _____		<input type="checkbox"/> CA-1, or <input type="checkbox"/> CA-2	CA-1 Nursing practice w/o medication privileges CA-2 Nursing practice with basic medication privileges
<input type="checkbox"/> Change from CA-1 to: _____		<input type="checkbox"/> CA-2 <input type="checkbox"/> CA-2A (APRN)	CA-2A – CA-2 with APRN guidelines CA-3 Nursing practice with full medication privileges including controlled substances, classes II-V
Effective CA-1 Date: _____			
<input type="checkbox"/> Change from CA-2/CA-2A to: _____		<input type="checkbox"/> CA-3 <input type="checkbox"/> CA-3A (APRN)	CA-3A – CA3 with APRN guidelines *Note: Must have handled basic medications for at least 6 months to advance from a CA2 to a CA3
Effective CA-2/A Date: _____			
Nursing Employment		*Are you current employed in a role that requires a nursing license? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes:	SARP employment approval date: _____	Employment start date: _____	
Job Title: _____	Are medications passed in this role? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Name of Organization: _____	Work location (city/town): _____		
**I am aware that I must submit Therapist and if it applies, employment supervisor recommendations prior to approval (for CA1 to a CA2, or a CA2 to a CA3 change).			<input type="checkbox"/> YES

Change in Therapy Frequency	Select One	
<input type="checkbox"/> Change from biweekly therapy to: _____	<input type="checkbox"/> monthly therapy <input type="checkbox"/> Therapy as needed (PRN)	
Please describe the progress in your recovery that supports this change (please attach additional documents as needed):   		
**I am aware that I must submit documentation from my therapist that speaks to this change request		<input type="checkbox"/> YES

SARP Participant Signature

Date Signed