The Commonwealth of Massachusetts
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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**
☐From No Nursing Practice to: ⟶	☐CA-1, or ☐CA-2	**CA-1** Nursing practice w/o medication privileges **CA-2** Nursing practice with basic medication privileges **CA-2A** – CA-2 with APRN guidelines **CA-3** Nursing practice with full medication privileges Including controlled substances, classes II-V **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
☐Change from CA-1 to: ⟶ Effective CA-1 Date:	☐CA-2 ☐CA-2A (APRN)	
☐Change from CA-2/CA-2A to: ⟶ Effective CA-2/A Date: _____	☐CA-3 ☐CA-3A (APRN)	

Nursing Employment	*Are you current employed in a role that requires a nursing license?			☐YES ☐ NO
If yes:	SARP employment approval date:		Employment start date:	
	Job Title:		Are medications passed in this role?	☐YES ☐ 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).**				☐YES

Change in Therapy Frequency	**Select One**
☐Change from biweekly therapy to:	☐monthly therapy ☐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**	☐YES

_____

SARP Participant Signature Date Signed

Form Revised January 6, 2023