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

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

KATHLEEN E. WALSH
Secretary

ROBERT GOLDSTEIN, MD, PhD
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

SARP: INITIAL LICENSEE SELF-ASSESSMENT DATA FORM

This form is to be completed by the SARP applicant. You may attach additional sheets as necessary for any section in this form. **This form may be faxed to (617)887-8786.**

NAME:

TODAY'S DATE:

ADDRESS:

DATE OF BIRTH:

AGE:

CONTACT INFO:

HOME #:

CELL#:

EMAIL:

LICENSE #:

LICENSE TYPE: ☐LPN ☐RN ☐Other: ☐APN: NA ☐APN: NM ☐APN: NP ☐APN: PC ☐APN: CRNA

SARP REFERRAL SOURCE (check all that apply**):**

☐Employer ☐Self ☐Family/friend ☐MD/provider ☐Lawyer ☐Therapist ☐Police ☐EAP
☐Board Investigator ☐SARP Coordinator ☐DPH Investigator ☐Board Committee ☐Other:

Please explain the events that lead to your referral to the SARP program. You may type in the box below. Please attach a separate sheet if necessary.

Describe your current work or most recent work setting in relation to your drug or alcohol use. Include information on ease of access to drugs, type of structure within the environment, amount and type of supervision available, general environment, and availability of employee assistance personnel.

Summarize your relationship with substances of abuse. Include how this relationship may have led to problems. Please attach additional sheets if necessary.

If you were previously enrolled in the SARP, please describe life and recovery experience events since you previously participated in the SARP.

PLEASE ANSWER THE FOLLOWING:

Have you ever ☐Yes ☐No

used substances intramuscularly/intravenously?

If yes, did this include needle sharing? ☐Yes ☐No

Has substance use ever affected your job (i.e. termination, demotion, etc.)? ☐Yes ☐No

Has your has substance use affected your health? ☐Yes ☐No

Does your substance use include abusing prescription drugs? ☐Yes ☐No

Does your substance use include abusing more than one substance concurrently? ☐Yes ☐No

Do you use or have you used substances on a daily or continuous basis? ☐Yes ☐No

On a scale from 1 to 5, how severe do you think your alcohol and/or substance use problem is? (Check a number.)

Not Severe ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Severe

SUBSTANCE USE SELF ASSESSMENT

Please identify your substance(s) of choice (including alcohol) in order of preference:

Preference	*Substance(s) of choice*	*Age of first use*	*Place/setting of first use*	*Date of last use*
#1				
#2				
#3				

Please check all the boxes that you feel accurately complete this sentence: "**I use a substance(s) to help with.**…"

☐Feeling confident ☐Increasing energy ☐Feeling comfortable ☐Feeling relaxed ☐Improving functioning
☐Sleep ☐Tolerating the day ☐Socializing ☐Forgetting things ☐Feeling "numb"
☐Overcoming loneliness ☐Overcoming emotional pain ☐Overcoming physical pain
☐Other(specify):

IMPACT OF SUBSTANCE USE:

Please answer the questions below regarding the physiologic, social, feeling, behavioral, and other impacts of your substance use:

Physiologic			**Social**		
To relieve tension?	☐No	☐Yes	Attempts to hide substance use?	☐No	☐Yes
Experience increase tolerance?	☐No	☐Yes	Continue use after others have stopped?	☐No	☐Yes
Consumed more than intended?	☐No	☐Yes	Others have complained about your use?	☐No	☐Yes
Experienced memory lapses?	☐No	☐Yes	Others have felt you have problem use?	☐No	☐Yes
			If applicable, your significant other is aware about your use?	☐No	☐Yes
			If applicable, you family/friends are concerned?	☐No	☐Yes
			If applicable, your significant other knows about your SARP application?	☐No	☐Yes

Do you feel….			**Behaviorally, substance use led you to…**		
Guilty about use?	☐No	☐Yes	Increase spending to obtain the substance(s)?	☐No	☐Yes
Irritated when use is discussed?	☐No	☐Yes	Do something illegal to obtain a substance(s)?	☐No	☐Yes
"Obsessed" about using?	☐No	☐Yes	Behave differently than if you were sober?	☐No	☐Yes
Eager for the next opportunity to use?	☐No	☐Yes			
Unease when substances not available?	☐No	☐Yes			

Have made attempt(s) to cease your substance use? ☐No ☐Yes, please identify below.

Date of attempt	*Method/significant information*	*Length of sobriety*

WITHDRAWAL HISTORY

Have you experienced any of the following signs/symptoms during any substance use withdrawal? (check all that apply)

☐Elevated vital signs	☐Anhedonia	☐Dizziness/light-headedness	☐Flushing	☐Tremors
☐Lowered vital signs	☐Seizures	☐Depression	☐Nausea	☐Urges/cravings
☐Emesis	☐Fever	☐Diarrhea	☐Restlessness	☐Diaphoresis
☐Irritability	☐Piloerection	☐Excess yawning	☐Photophobia	☐Hallucinations-Tactile
☐Mood swings	☐Myalgia	☐Arthralgia	☐Ostealgia	☐Hallucinations-Auditory
☐Insomnia		☐Abdominal cramps		☐Hallucinations-Visual
☐Other:				☐Hallucinations-Olfactory

Have you ever participated in structured mental health or substance use withdrawal services? ☐ No ☐Yes, please identify below. Please attach a separate sheet if necessary.

Dates	*Program name & location*	*Length of treatment*	*Treatment type (select one per row)*
			☐Inpatient ☐Intensive outpatient ☐Supervised withdrawal services (“detox”) ☐Counseling/groups ☐Transitional living
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			☐Inpatient ☐Intensive outpatient ☐Supervised withdrawal services (“detox”) ☐Counseling/groups ☐Transitional living

RECOVERY ACTIVITIES

Please describe your historic & current involvement with the self-help groups below. Please note “N/A” if appropriate.

Group and Individual	*Current or historic involvement*	*Currently attend*
Alcoholics Anonymous		*# of*
Narcotics Anonymous		*# of mtgs/week:*
A Way of Life (AWOL)		*# of mtgs/week:*
SMART Recovery		*# of*
Other Group:		*# of mtgs/week:*
Do you have a sponsor?	☐No ☐Yes, first name:	Contact frequency: ☐ daily ☐weekly
Do you work with a Recovery Coach?	☐No ☐Yes, first name:	☐ daily ☐weekly

COMPULSIVE BEHAVIOR IDENTIFICATION
(check all which you currently feel may apply to you)

☐Substance use ☐Gambling ☐Sex/intimacy ☐Excess food consumption
☐Excess working/ "workaholic" ☐Other risk-taking activities ☐Other:

OTHER PROFESSIONAL REGISTRATIONS
Please list all of the professional licenses held. Please attach additional sheets as necessary

State	*License Type & License #*	*License status (e.g active, restricted)*

Please list any previous or current complaints against your Professional license, in Massachusetts or another state:

State	*Name of Board*	*License Type & license #*	*Action & Current status*

PROFESSIONAL EDUCATION

Program title	*School/university*	*Degree/cert.*	*Year graduated*

CURRENT EMPLOYMENT

Position held	*Employer (include supervisor name & #)*	*Hours/week*	*Years in position*

PREVIOUS EMPLOYMENT HISTORY

Position held	*Employer*	*Years in position*	*Reason for leaving*

Are there any current special practice provisions in place? ☐No ☐ Yes. If yes, please specify in the space below

Were you terminated from any of your past professional positions? ☐No ☐ Yes. If yes, for what reason? Please explain in space below. Please attach additional sheets as necessary.

SUMMARY OF CURRENT EMPLOYMENT STATUS: (check all that apply)

☐Terminated ☐Leave of Absence ☐Medical Leave ☐Disability Leave ☐Administrative Leave
☐Employed in Profession- Employer is aware of problem ☐Unemployed since:
☐Employed in Profession- Employer is unaware of problem ☐Other:

MEDICAL HISTORY

Please describe significant past and present non-psychiatric medical problems including work-related injuries, chronic illnesses/disorders and surgeries. Please attach a separate sheet if necessary.

Medical problem	*Current/historic*	*Diagnosis date*	*Treatment*

BEHAVIORAL HEALTH HISTORY

Please describe significant past and present psychiatric/behavioral health problems. Please **do not** include any problem or treatment that was only related to drug or alcohol use. Please attach a separate sheet if necessary.

Diagnosis	*Current/historic*	*Diagnosis date*	*Treatment*

If yes, please describe briefly in the space provided. Please attached a separate sheet if necessary:

Have you experienced functional impairing anxiety?	☐No ☐Yes	
Have you ever experienced panic attacks?	☐No ☐Yes	
Have you attempted or thought about suicide? If yes, are your providers aware and has this been assessed recently?	☐No ☐Yes ☐No ☐Yes	
Are you working with a therapist? **If no, are you actively trying secure one?**	☐Yes ☐No ☐Yes ☐No	**If yes, what is their name?:**

CURRENT TREATMENT PROVIDERS

Provider name	*Specialty*	*Last visit*	*Phone Number/City/town, State*

CURRENT MEDICAL/PSYCHIATRIC MEDICATION

Please identify the medications you are currently prescribed as well as commonly used over-the-counter drugs. Please attach a separate sheet if necessary.

Medication	*Indication*	*Date first prescribed*	*Dosage & frequency*	*Prescriber Name*

PAST/PRESENT LEGAL HISTORY

Please describe the charges and disposition of any legal matters you are involved with:

Have you ever been arrested? ☐No ☐Yes

Have you ever been arrested while under the influence of drugs or alcohol? ☐No ☐Yes

Have you ever been arrested for possession or distribution of any controlled substances? ☐No ☐Yes

Have you ever been incarcerated? ☐No ☐Yes

Please explain if you answered yes to any of the legal history questions above. Please attach additional sheets as necessary:

Are you working with an Attorney? ☐No ☐ Yes If yes, please provide the information in the adjacent space → ***Please ensure a Release of Information form is submitted to allow SARP staff to communicate as needed.**	Name:	
	Phone:	
	Fax:	
	Address:	
Do you currently or will you have a Probation Officer. ☐No ☐ Yes If yes, please provide the information in the adjacent space → ***Please ensure a Release of Information form is submitted to allow SARP staff to communicate as needed.**	Name:	
	Phone:	
	Fax:	
	Address:	