Maryland Professional **Rehabilitation** Program

1202 Maryland Ave,
Baltimore, MD 21201-5512
Phone: 410.878.9843
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PRACTITIONER INFORMATION

Quarterly Update

As a part of your Rehabilitation Agreement, the program is required to report quarterly updates to the Board of Physicians***. This Form must be completed by the date checked.***

☐ MARCH 31 ☐ JUNE 30 ☐ SEPTEMBER 30 ☐ DECEMBER 31

NAME:_____

PLEASE UPDATE ALL RELEVANT INFORMATION SINCE THE LAST QUARTERLY REPORT

TYPE OF INVOLVEMENT WITH BOP (CHECK) ☐ ***BOARD ORDER*** ☐ ***DISPOSITION AGREEMENT***

HAS YOUR STATUS WITH THE BOARD CHANGED SINCE THE LAST REPORT? ☐ ***UNCHANGED*** ☐ ***CHANGED***

IF CHANGED, EXPLAIN:_____

CHECK HERE IF UNCHANGED FROM THE LAST REPORTING QUARTER ☐ ***OR PROVIDE UPDATE(S).***

PHYSICIAN MEDICAL SPECIALTY (LIST ALL:) _____

NON-PHYSICIAN FIELD/SPECIALTY:_____

Home Phone:_____ Can we leave a message? Yes No

Work:_____ Can we leave a message? Yes No

Cell:_____ Can we leave a message? Yes No

Email: _____ Private e-mail account? Yes No

PREFERRED METHOD OF CONTACT:_____

PREFERRED ADDRESS:_____

_____

EMERGENCY CONTACT:_____ RELATIONSHIP: _____

PHONE:_____ ADDRESS/EMAIL: _____

_____

IF YOU ARE CURRENTLY PRACTICING, PLEASE CIRCLE PRACTICE SETTING (S): (CIRCLE)
N/A Solo Private Group Hospital HMO Private Clinic Public Clinic
Retired Other:_____

STATES IN WHICH YOU CURRENTLY HOLD A LICENSE/CERTIFICATE (ALL): ☐ ***UNCHANGED FROM LAST REPORT***

1._____ 2._____

LIST HOSPITALS AND HEALTH ORGANIZATIONS WHERE PRIVILEGEDOR PLACE OF PRACTICE/EMPLOYMENT:
☐ ***UNCHANGED FROM LAST REPORTING PERIOD***

1._____

2._____

3._____

LIST RENEWAL DATES FOR YOUR STATE LICENSE(S); OR, IF YOU ARE APPLYING FOR A NEW LICENSURE IN THIS STATE OR OTHER STATES IN THE **UPCOMING QUARTER**, PLEASE LIST YOUR APPLICATION DATE: ☐ **NOT APPLICABLE**

1._____DATE:_____ 2._____DATE:_____

3._____DATE:_____ 4_____DATE:_____

PLEASE LIST RENEWAL DATES FOR ANY CERTIFICATION(S) IN THE **UPCOMING QUARTER**; OR, IF YOU ARE APPLYING FOR A NEW CERTIFICATE, PLEASE LIST CERTIFICATION AND APPLICATION DATE(S): ☐ **NOT APPLICABLE**

1._____DATE:_____ 2._____DATE:_____

Number of appointments both scheduled and attended. ***Information provided will be verified.***

	Month 1	**Month 2**	**Month 3**
Number of out-patient sessions scheduled/attended	/	/	/
Number of group sessions scheduled/attended	/	/	/
Number of medication management sessions scheduled/attended	/	/	/
Number of 12-step meetings recommended/attended	/	/	/

Please list any other treatment, seminars, educational meetings, CMEs and other experiences that pertain to your involvement with this program:_____

_____

_____

Medication changes since last reporting period (type, dosage, and frequency):

MEDICATION:_____DOSAGE:_____FREQUENCY:_____

MEDICATION:_____DOSAGE:_____FREQUENCY:_____

MEDICATION:_____DOSAGE:_____FREQUENCY:_____

MEDICATION:_____DOSAGE:_____FREQUENCY:_____

Please Return This Form Via Fax or Mail to the Information Provided One Week Before The Due Date.