



**Maryland Physician Health Program**  
*Helping physicians and the medical community for more than 30 years*

1202 Maryland Ave, 2<sup>nd</sup> Floor  
 Baltimore, MD 21201-5512  
 Phone: 800.992.7010/410.962.5580  
 Fax: 410.962.5584  
 www.healthymaryland.org

**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 PRIVILEGED OR 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 LICENSE 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.**