(This information is necessary for our files and will be considered confidential.)

Participant's Name: _____ **Suffix**: _____
(Last) (First) (Middle)

Credential: MD _____DO _____PA _____Resident _____Student _____ Specialty: _____

Date of Birth_____ Marital Status: Married _____ Single _____ Divorced _____ Widowed _____ Other _____

Voluntary/Mandated_____ Out of State Monitoring _____

Sobriety Date _____ Are you a member of the Kansas Medical Society? ( ) Yes ( ) No

HOME:

Address _____ Home phone _____ Can we leave a v/m Yes__ No __

City/State/Zip_____ Cell # _____ Can we leave a v/m Yes__ No __

Home email _____ Alternative Email _____

WORK: *(Use reverse if additional space is needed.)* **Unemployed:** Yes _____

Practice Name_____ Work phone _____ Can we leave a v/m Yes__ No __

Address _____ Work Fax # _____

City/State/Zip_____ Work Email _____

Work Supervisor _____ Supervisor's Phone #_____
Can we leave a v/m Yes___ No ___

Worksite Monitor _____ Monitor's Phone #_____
Can we leave a v/m Yes___ No ___

Hospital(s) where privileged _____

Hospital Phone _____ *(Use reverse if additional space is needed.)*

EMERGENCY CONTACT:

Name: _____ Relationship to Participant _____

Address _____

City/State/Zip _____

Phone Number _____ Can we leave a v/m Yes__ No __ Cell Number _____ Can we leave a v/m Yes__ No __

LICENSING INFORMATION

Kansas # _____ Status _____

Other state(s) #_____ Status _____

Other state(s) #_____ Status _____

REFERRAL SOURCE: *Relationship (check one)*

( ) Self
( ) Hospital
( ) Therapist
( ) Colleague
( ) Primary care physician
( ) Medical school
( ) Attorney
( ) Hospital administration
( ) Spouse
( ) Licensing board
( ) Patient
( ) Residency director
( ) Hospital physician assistance committee
( ) Family member _____
( ) Malpractice carrier _____
( ) Other state physician health program_____
( ) Other _____

THERAPIST: ( ) Not Applicable

Last Name _____ First Name _____ Suffix _____ Degree _____

Address _____City _____

State _____ Zip _____ Phone _____ Email _____

PSYCHIATRIST: ( ) Not Applicable

Last Name _____ First Name _____ Suffix _____ Degree _____

Address _____City _____

State _____ Zip _____ Phone _____ Email _____

PRIMARY CARE PHYSICIAN: ( ) Not Applicable

Last Name _____ First Name _____ Suffix _____ Degree _____

Address _____City _____

State _____ Zip _____ Phone _____ Email _____

ATTORNEY: ( ) Not Applicable

Last Name _____ First Name _____ Suffix _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

OTHER INFORMATION:

Treatment: ( ) Evaluation and/or Treatment ( ) Inpatient ( ) Outpatient ( ) Not Applicable

Facility _____ Date Entering _____

Therapy Frequency _____

Facility _____ Date Entering _____

Therapy Frequency _____

Facility _____ Date Entering _____

Therapy Frequency _____

Support Group Meetings:

Name _____ Location _____ Frequency _____

Name _____ Location _____ Frequency _____

PAST AND/OR PRESENT MEDICAL BOARD, COURT SYSTEM, STATE OR HOSPITAL MONITORING PROGRAM INVOLVEMENT: *(Use reverse if additional space is needed.)*

Name: _____

Contact Person: _____ Phone # _____

Email Address: _____

Name: _____

Contact Person: _____ Phone # _____

Email Address: _____

Name: _____

Contact Person: _____ Phone # _____

Email Address: _____

Please attached copies of any medical board, court, monitoring or treatment records, especially assessment and discharge summary/recommendations you may have in your possession. If these are available to you, please contact the facility or agency and request that your records be forwarded to Kansas Medical Society-Professionals' Health Program (KMS-PHP)

Completed by _____ Date _____
(Please print)

Participant Signature _____

KMS-PHP Representative Signature _____