PACIFIC ASSISTANCE GROUP
PROFESSIONAL MONITORING & SUPPORT
3231 Ocean Park Boulevard, Suite 201 Santa Monica, CA 90405

TRACY R. ZEMANSKY, Ph.D.
TEL: 310/664-0454
FAX: 310/559-8743
www.pacificassistancegroup.net

The Pacific Assistance Group (PAG) is a private monitoring and support services program. The Mission of the PAG program is to assist healthcare providers to help themselves in their recovery and rehabilitation in order to competently practice their profession and ensure public protection.

MONITORING AGREEMENT FOR: _____

DATE OF AGREEMENT: _____

I recognize I may have a substance abuse related and/or a mental health disorder. I understand and agree that my participation in this private monitoring and support services program (PAG) does not affect, alter, or curtail in any manner, the Medical Board of California's or any other Board's authority to investigate and take disciplinary action against my license for unprofessional conduct committed by me, whether this conduct occurred before, during, or following my participation in this program.

I understand the PAG Program Administrator's priorities are to protect the public's safety and welfare and to assist me to help myself. I understand the Program Administrator will guide and support me in my rehabilitation and recovery process. I also understand this monitoring and services program strictly adheres to a zero tolerance policy regarding unauthorized drug usage and/or alcohol consumption.

PAG services requested or required by the healthcare provider participant or referral entity, and the duration of monitoring services will be tailored to each participant. I agree to comply with the terms and conditions as outlined in this Agreement.

1. **LENGTH OF PROGRAM**
   I agree to remain in the PAG private monitoring and support services program for _____ . The length of the program and support services may be extended, at which time I will sign a new Agreement. The extension will occur only with my written approval.

2. **EXPENSES/FEES**
   Fees will be based on services provided. I am personally responsible for all fees connected and associated with this private monitoring and services program. I agree to pay the Program Administrator's monthly fee in advance, no later than the first Monday of each month. The monthly fee of $_____covers only case management and facilitated Health Support Groups with the PAG program.

3. **LAWS**
   I will obey all local, state, and federal laws, and I will immediately report by telephone any arrest, conviction or questioning by law enforcement to the program administrator.

PACIFIC ASSISTANCE GROUP
PROFESSIONAL MONITORING & SUPPORT
3231 Ocean Park Boulevard, Suite 201 Santa Monica, CA 90405

TRACY R. ZEMANSKY, Ph.D.
TEL: 310/664-0454
FAX: 310/559-8743
www.pacificassistancegroup.net

4. **HEALTH SUPPORT GROUPS**

I agree to attend two (2) facilitated Health Support Groups per week for the first twenty-four (24) months in this program unless directed otherwise by my Referring Entity or the PAG Program Administrator. Each group is one-and-a-half (1.5) hours in duration. I will arrive on time and will not leave until the end of group. If I have to miss a group(s) for an anticipated reason such as work, vacation, conference, class, or family, I will request approval in writing from the Program Administrator at least one (1) week, preferably two (2) weeks, in advance.

In those instances when I am unable to attend group because of an unanticipated situation such as car breakdown, illness, car accident, or family issue, I will telephone the Program Administrator on the day/evening of the group and give my explanation. I will write a brief note of explanation for the absence to be placed in my file, if requested to do so.

I understand that what is shared in the Health Support Groups is confidential with the following exceptions:

A. Information the Program Administrator deems necessary to share with outside entities in accordance with the law and/or my signed release of confidential information.

B. Disclosures required by law, without my written or verbal permission:
- Clear intention to do harm to others or myself;
- Notification to appropriate Social Service Agencies of any suspicion of emotional, physical, sexual abuse, or neglect of a child, a disabled person, or an elderly person.
- Cooperation with Board investigations (as required by law).

5. **12-STEP MEETINGS, RECOVERY SUPPORT GROUPS**

Prior to returning to work and/or during the first ninety (90) days following my completion of an in/outpatient treatment program, I will attend seven (7) weekly 12-step meetings (Alcoholics Anonymous, Narcotics Anonymous, Pills Anonymous, other 12-step meetings, or other recovery support groups) as directed by the Program Administrator. Once I am working, the number of 12-step meetings or other recovery support groups may be reduced by the Program Administrator to a minimum of three (3) per week.

I agree to attend _____ weekly 12-step meetings or other recovery support groups as directed by the Program Administrator. I understand these meetings or recovery support groups are in addition to the facilitated Health Support Groups. If required to do so, I will provide written verification of my attendance at 12-step meetings or other recovery support groups, and submit these to the Program Administrator by the first Monday of each month. Forms will be provided.

6. **12-STEP SPONSOR**

I will obtain a 12-step sponsor with a minimum of five (5) years of recovery within thirty (30) days of signing this document. I agree to work the 12 Steps in writing with my sponsor. My sponsor will have a sponsor him or herself and will also have worked/ be working the 12 Steps in writing. I will have telephone contact with my sponsor at least _____times weekly and will see him/her in person at least ____times weekly/monthly.

7. **INTERNATIONAL DOCTORS IN AA CONFERENCE**

I will attend the International Doctor's In AA (IDAA) Conference (if necessary I may request a Scholarship) during my initial year with PAG. I agree to notify my employer that attendance at this conference is a mandatory part of my recovery Agreement.

8. **WORKSITE/HOSPITAL MONITORS**

I will obtain worksite and/or hospital monitor(s) at each worksite and hospital where I am working. The monitor(s) may not be in my employment, beholden to me in any way, related to me, or under my supervision. The monitor(s) will observe my condition at the worksite and hospital. Each monitor is to have ongoing face-to-face contact with me on a weekly basis.

I will sign a Release of Confidential Information form, allowing the Program Administrator to verbally provide each monitor with the circumstances leading to my involvement in PAG and the expectations of PAG participants. The signed Release of Confidential Information form will allow each of my monitors to provide quarterly written or verbal reports, as required, to the Program Administrator. The monitor(s) will immediately inform the Program Administrator by telephone of any suspicion of my use of drugs/alcohol, any other questionable behavior, or appearance of inappropriate behavior (such as missed work, late arrival to work or any concerns they may have regarding my safe practice of medicine). Prior to beginning work or returning to any previous worksite, I will submit the names, addresses and telephone numbers of all my worksite/hospital monitors to the Program Administrator.

9. **QUARTERLY REPORTS FROM WORKSITE/HOSPITAL MONITORS**

Forms will be provided for each worksite and/or hospital monitor to submit quarterly written or verbal reports, as required, to the Program Administrator on the last day of March, June, September and December. It is my responsibility that these reports or verbal contacts be provided as scheduled.

10. **EVALUATIONS**

If directed by the Program Administrator, in collaboration with outside entity(ies), I will undergo a substance abuse related disorder and/or psychological/psychiatric evaluation at my own expense. A copy of the evaluation will be sent to the Program Administrator.

PACIFIC ASSISTANCE GROUP
PROFESSIONAL MONITORING & SUPPORT
3231 Ocean Park Boulevard, Suite 201 Santa Monica, CA 90405

TRACY R. ZEMANSKY, Ph.D.
TEL: 310/664-0454
FAX: 310/559-8743
www.pacificassistancegroup.net

11. **PSYCHIATRIC, PSYCHOLOGICAL COUNSLEING AND/OR TESTING, NEUROLOGICAL TESTING, PSYCHOTHERAPY, MEDICATIONS**

Following the Program Administrator's consultation with outside services (i.e. treatment program, addictionologist, etc.), I may be directed to receive counseling/psychotherapy, testing, and/or medication. If directed by the Program Administrator, I will engage in individual psychotherapy and/or psychiatric medication management, and/or psychiatric/psychological testing at my own expense. I may be directed to take Naltrexone and/or Antabuse unless contraindicated by my primary care physician.

The healthcare provider I choose for services must be licensed and/or board certified and approved by the Program Administrator. An approved list of healthcare providers is available upon request.

12. **QUARTERLY REPORTS FROM HEALTHCARE PROVIDERS**

I will have each healthcare provider submit quarterly written or verbal reports, as required, to the Program Administrator. I understand the reports do not request any disclosure of the content of my individual sessions. I will sign a Release of Confidential Information form for my healthcare providers to submit these quarterly written or verbal reports, if requested to do so. The quarterly reports are to be submitted prior to the last day in March, June, September and December. It is my responsibility that these reports are submitted as scheduled. Forms will be provided. In addition, the Program Administrator may consult with my healthcare providers for my ongoing recovery and support.

13. **PRIMARY CARE PHYSICIAN AND PRESCRIPTIONS**

I will obtain a primary care physician who is knowledgeable about my addiction history and/or mental health condition. I will provide the Program Administrator with the name and telephone number of this physician and sign a Release of Confidential Information form. I will provide the Program Administrator with a copy of all prescriptions written for me prior to having them filled. I will report all personal use of prescription drugs and the name and telephone number of the prescribing physician.

No adverse consequences will occur when my test results indicate drug usage for a drug(s) that I have been approved to take following consultation with an addictionologist and/or any other specialist requested of me, and the Program Administrator.

14. **ZERO TOLERANCE, SELF-PRESCRIBING/USE**

I understand that zero tolerance means I will abstain from the use of all alcohol and all legal or illegal drugs except those prescribed for me by another physician and approved of in advance as indicated above. If I am in an emergency situation (i.e.: emergency room, severe accident etc.) and am required to receive medication, I (or my next of kin) will notify the Program Administrator of what has occurred as soon as feasibly possible.

I will not self-prescribe any medication. I will not use any over the counter medications (other than aspirin, multi-vitamins etc.) without discussing this with my primary care physician and the Program Administrator prior to taking these. Within twenty-four (24) hours, I will report by telephone any use of alcohol and/or unauthorized drugs to the Program Administrator. I will obtain a copy of the Talbott Recovery Campus Medication Guide (www.talbottcampus.com) © and am responsible for following those guidelines.

15. **DRUG/ALCOHOL TESTING**

I will utilize only the approved collection company/ies and approved lab facility/ies for the PAG program, and the Program Administrator has no vested interest in either of these. Collection by non-approved company/ies or lab/s will not be accepted as valid by the Program Administrator. I agree to submit to random, monitored, biological fluid testing that will be observed at a frequency as directed. I will have a minimum of _____ tests per_____ for the duration of this Agreement. Any changes in frequency of testing/ observed testing must be indicated in writing in an Agreement Addendum signed by both myself and the Program Administrator.

Testing is on a 7 days/week random basis, which includes weekend and holiday collections. I am responsible to have a 24/7 testing facility for use as necessary. I will sign a Release of Confidential Information form so that all lab results will be sent to the Program Administrator. I am responsible to pay for all costs related to collections and lab fees.

16. **CONSEQUENCE OF POSITIVE DRUG/ALCOHOL TEST**

Any positive screen or test for alcohol, marijuana and/or any other drug(s) legal (but not authorized) or illegal, will result in the Program Administrator immediately directing me to stop work. I will not complete my shift should I receive this directive at work. I understand that being immediately removed from my work as a healthcare provider is to protect the public. The Program Administrator will notify those persons at my worksite to whom I have given prior approval and a signed Release of Confidential Information form, that I have been directed to immediately stop working and the reason for this.

I agree to remain out of practice/work during the time period the positive test result is being investigated. The investigation (portions of which will be at my expense) will include the Program Administrator contacting my monitors. In addition, the investigation may include: (1) an evaluation by an addictionologist or treatment program and (2) contacting my healthcare providers and (3) contacting the Medical Review Officer (MRO). Following the investigation, I will return to work/practice, which may include reduced work hours, only at the direction of the Program Administrator.

17. **AVOIDING "FALSE" POSITIVES**

I agree to avoid all over-the-counter medications and other substances listed on a document available online or from my Program Administrator. Inadvertently ingesting anything on the list will not avoid consequences for a positive test or screen result, even if it is a "false" positive.

PACIFIC ASSISTANCE GROUP
PROFESSIONAL MONITORING & SUPPORT
3231 Ocean Park Boulevard, Suite 201 Santa Monica, CA 90405

TRACY R. ZEMANSKY, Ph.D.
TEL: 310/664-0454
FAX: 310/559-8743
www.pacificassistancegroup.net

18. **TREATMENT PROGRAMS**

If I am directed to do so, I will enter a treatment program within one (1) to seven (7) days, if the Program Administrator and an independent outside evaluator (addictionologist, treatment program evaluation team, or other healthcare provider) believe that treatment is necessary in order for me to work safely as a healthcare provider. The cost of this evaluation and treatment will be at my expense. I will be given names of approved treatment programs.

19. **IMPAIRMENT – CEASE OR RESTRICT WORK**

I agree to restrict or cease my work as a healthcare provider if the Program Administrator, in collaboration with other entities with whom I have signed Release of Confidential Information forms, determine that I am impaired.

Impairment is defined as:

A. Practicing while under the influence of alcohol or other drugs.
B. Practicing with symptoms of mental or emotional illness requiring professional assessment.
C. Submitting a biological fluid sample resulting in a positive drug/alcohol test.
D. Refusing to submit to biological fluid testing.
E. Attending the health support group while under the influence of alcohol and/or drugs, or displaying a mental or emotional illness.
F. Documented reports from worksite monitor of unsafe medical practice performance.

20. **NON-COMPLIANCE**

If I am in non-compliance with any of the terms and conditions of this Agreement, I agree to be evaluated as directed by the Program Administrator at my own expense, to determine the next indicated steps regarding my recovery and rehabilitation.

21. **REFUSAL TO FOLLOW ANY DIRECTION/DISCHARGE**

In those instances when I use alcohol and/or unauthorized drugs and/or have a mental health condition, and I refuse to submit to biological fluid testing or refuse to follow the directives of the Program Administrator regarding in/outpatient treatment or refuse to follow any direction of the Program Administrator pertaining to my recovery and the protection of the public, I may be considered to be an impaired healthcare provider and the program administrator may:

A. Discharge me from the PAG program.
B. Immediately contact by telephone and in writing my Well-Being Committee, worksite and hospital monitor(s), head of my group practice and others for whom I have signed Release of Confidential Information forms. The program administrator will provide the date and reason for my discharge from PAG to these persons.

PACIFIC ASSISTANCE GROUP
PROFESSIONAL MONITORING & SUPPORT
3231 Ocean Park Boulevard, Suite 201 Santa Monica, CA 90405

TRACY R. ZEMANSKY, Ph.D.
TEL: 310/664-0454
FAX: 310/559-8743
www.pacificassistancegroup.net

21. **CONFIDENTIALITY**

All written and verbal interactions between me and the Program Administrator are personal and confidential with the following exceptions:

A. Any and all entities i.e. Well-Being Committees, physicians, therapists, designated representatives, professional licensing agency, etc. listed by me and with my signed Release of Confidential Information forms.
(Verbal and written communication, as well as appearances by the Program Administrator at the Well-Being Committee, will be made as requested with my written authorization.)

B. Information the program administrator deems necessary to share with outside entities in accordance with the law and/or my signed Release of Confidential Information forms.

C. Disclosures required by law, without my written or verbal permission:
- Clear intention to do harm to others or myself;
- Notification to appropriate Social Service Agencies of any suspicion of emotional, physical, sexual abuse, or neglect of a child, a disabled person, or an elderly person.
- Cooperation with Board investigations (as required by law).

22. **RELEASE OF LIABILITY**

I have requested the Program Administrator to monitor, case manage and facilitate my Health Support Group as it pertains to my recovery and rehabilitation from drugs, alcohol and/or mental health problems. This process requires both subjective and objective observation and evaluation. As part of this process, the Program Administrator will observe and monitor my rehabilitation, progress, and recovery. The Program Administrator will report observations and opinions to all persons in accordance with the law and with my signed Release of Confidential Information forms. I hereby agree to indemnify and hold PAG and the Program Administrator harmless from any claim arising from the services rendered under this contract/agreement. I agree not to sue PAG, the Program Administrator or any PAG associates for any actions taken under this Agreement.

I have read this Agreement carefully and have had all of my questions concerning this document answered. I understand this Agreement and agree to comply with the terms and conditions stated within.

_____

Participant Printed Name Participant Signature Date/Time

_____

Tracy R. Zemansky, Ph.D. Date/Time
Program Administrator/Group Facilitator