COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
PROFESSIONAL HEALTH MONITORING PROGRAMS
PO BOX 10569
HARRISBURG, PA 17105-0569
800-554-3428
717-783-4857
www.dos.pa.gov/phmp

PARTICIPATION COOPERATION FORM

Please review the following aspects of the Professional Health Monitoring Programs (PHMP), Voluntary Recovery Program (VRP), carefully before signing and returning this form:

1. The licensee will sign (if eligible) a "PHMP Agreement" deferring formal disciplinary action (i.e. suspension or revocation).
2. The licensee will, at his/her own expense, if enrolled, participate in a PHMP-approved assessment and/or treatment.
3. The licensee will, at his/her own expense, if enrolled, participate in any aftercare plan developed with the primary treatment provider, and agree to be monitored by the PHMP for a period of not less than three years.
4. When enrolled, no disclosure, publication, or public record will be made of the "PHMP Agreement", subject to the licensee's progress in and successful completion of the PHMP.
5. If enrolled, failure to comply with the terms of the "PHMP Agreement" will result in initiation of the formal disciplinary process against the professional's license to practice.

I agree to cooperate with the PHMP and to provide any information necessary to determine my eligibility/ineligibility for the program.

I, _____, voluntarily **agree** to cooperate with the PHMP.

_____	_____	_____
Licensee signature	Date	Social Security Number

If you choose not to cooperate with the PHMP, please so indicate by your signature below, and append a brief statement outlining your reason(s) for so choosing.

Having read the terms and conditions of participation in the PHMP, and reviewed the above

I, _____, voluntarily **decline** to cooperate with the PHMP.

_____	_____	_____
Licensee signature	Date	Social Security Number