

**Virginia Health Practitioners' Monitoring Program  
Quarterly Peer Monitor Report**

Name of Participant: \_\_\_\_\_ Client # \_\_\_\_\_ CM: \_\_\_\_\_

Date of Report: \_\_\_\_\_ For Month: \_\_\_\_\_, 20\_\_\_\_

**Did Program Participant make contact with you?**

If yes, means of contact:

	Yes	No	Telephone	Face to Face	Email
Week 1:	<input type="checkbox"/>				
Week 2:	<input type="checkbox"/>				
Week 3:	<input type="checkbox"/>				
Week 4:	<input type="checkbox"/>				

**Please tell us your assessment of this individual's status:**

Very Good  Good  Fair  Poor  Very Poor

**Do you have any concerns about the participant's recovery, behavior or work performance?**

Yes  No

**Comments/Concerns:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you need more information about the Health Practitioners' Monitoring Program (HPMP) or the participant?**

Yes  No

**Do you need to speak with the participant's case manager?**

Yes  No

**As far as you are aware, does the participant comply with the standards of acceptable and prevailing practice and appear able to practice with reasonable skill and safety?**

Yes  No

**Do you have concerns about the participant's behavior or compliance with HPMP?**

Yes  No

Person Completing Report (Print Name): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Telephone: \_\_\_\_\_

*(Please fax this form to 804-828-5386 by the 10<sup>th</sup> of March, June, September and December.)  
Thank you for your cooperation!*

**For Office Use Only**

Date Received by HPMP: \_\_\_\_\_ Case Manager: \_\_\_\_\_