

**Virginia Health Practitioners' Monitoring Program
Monthly Witnessed Vivitrol**

Name of Participant: _____ Client # _____ CM: _____

Month: _____, 20____

Date	Naltrexone Dose	Name of Witness <i>(please print)</i>	Signature of Witness
_____	_____	_____	_____

REPORTS ARE DUE BY THE 10TH OF EACH MONTH

For Office Use Only

Date Received by HPMP: _____ Case Manager: _____