Virginia Health Practitioners' Monitoring Program
Monthly Witnessed Antabuse

Name of Participant: _____ **Client #** _____ **CM:** _____

Month: _____, 20_____

Date	Antabuse Dose	Name of Witness *(please print)*	Signature of Witness	*Relation to Client

*e.g., Work Site Monitor, Therapist, Employee Health, etc.

REPORTS ARE DUE BY THE 10TH OF EACH MONTH

For Office Use Only
Date Received by HPMP: _____ Case Manager: _____