Virginia Health Practitioners' Monitoring Program
Monthly Peer Monitor Report

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

Date of Report: _____ **For Month:** _____, 20_____

Did Program Participant make contact with you?

	Yes	No	If yes, means of contact: Telephone	Face to Face	Email
Week 1:	☐	☐	☐	☐	☐
Week 2:	☐	☐	☐	☐	☐
Week 3:	☐	☐	☐	☐	☐
Week 4:	☐	☐	☐	☐	☐

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 10th of the month.)
Thank you for your cooperation!

For Office Use Only

Date Received by HPMP: _____ Case Manager: _____