Wisconsin Department of Safety and Professional Services

Mail to:	P.O. Box 7190 Madison, WI 53707-7190	Location:	4822 Madison Yards Way Madison, WI 53705
FAX #:	(608) 266-2264	Email:	DSPSImpairedProfessionalProcedure@wi.gov
Phone #:	(608) 266-2112	Website:	http://dsps.wi.gov

PROFESSIONAL ASSISTANCE PROCEDURE

WORK SUPERVISOR REPORT FORM

Complete this form and submit it to PAP on or before each quarterly due date. You may copy this blank form so you have forms for future reports. It is recommended you keep a copy of each completed form for your files.

Please Print Clearly

Name of Employee: ____
Last First Middle

Place of Employment: ____
Name of Employer Type of Facility

Address of Employment: ____
Street City State Zip Code

Employee's Job Title: ____

Date Report is Due: ____________________ Dates of Employment: ____________________
Month / Day / Year Month / Day / Year

Hours of Employment: ______________________ Full-time? _____ Yes _____ No
Part-time? _____ Yes _____ No

Name and Position of Immediate Supervisor: ______________________________
Last First Middle

1. Describe the employee's job responsibilities in the last 3 months. ______________________
____
____
____

2. Describe the employee's quality of work in the last 3 months. ______________________
____
____
____

3. Does this employee have access to controlled substances? _____ Yes _____ No
Does this employee administer controlled substances? _____ Yes _____ No
Does this employee dispense controlled substances? _____ Yes _____ No
Have there been any problems with this? _____ Yes _____ No
If yes, describe further.

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4. Describe attendance problems in the last 3 months. ______________________________

5. Describe employee's relationships with others (patients, clients, coworkers) in the last 3 months. _____

6. Has this employee had a work performance evaluation during the last 3 months? _____ Yes _____ No
   If yes, enclose a copy. ______________________________

7. To the best of your knowledge, do you believe this employee is remaining abstinent from all mood-altering substances, including alcohol? _____ Yes _____ No
   If no, explain further. ______________________________

8. List others at your facility involved in monitoring this employee.
   Name: ______________________________
   Last First Middle Title
   Name: ______________________________
   Last First Middle Title
   Name: ______________________________
   Last First Middle Title

9. Additional coments, questions or concerns: ______________________________

______________________________ ______________________________
Signature Date

____
Print Name

(_____) ______________________________
Phone Number

Return the completed form to "PAP" at the above address. (Attach additional sheets if necessary.)