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
Phone #: (608) 266-2112

Email: DSPSImpairedProfessionalProcedure@wi.gov
Website: http://dsps.wi.gov

PROFESSIONAL ASSISTANCE PROCEDURE

APPLICATION FOR PARTICIPATION

The Professional Assistance Procedure (PAP) is a voluntary, non-disciplinary monitoring program that may be offered to credential holders when alcohol and/or drug abuse allegations have been made. If eligible, it will be necessary for you to sign an ***Agreement for Participation*** that describes the requirements for participation, as well as a statement of facts which may be used as a basis for further action upon violation of the ***Agreement for Participation***. Compliance with the ***Agreement for Participation*** allows you to obtain/retain your professional credential, subject only to possible work restrictions deemed necessary. Participation in PAP will not bar investigation of, or disciplinary action based upon, information or allegations of misconduct.

By completing this application, you are expressing your desire to be considered for participation in PAP.

Please Print Clearly

APPLICANT

Name: _____
Last First Middle License #

Address: _____
Street City State Zip Code

Home Phone: (____) _____ Work Phone: (____) _____

Email Address: _____

EMPLOYMENT

Current Employer: _____

Employer Address: _____
Street

_____
City State Zip Code

Work Supervisor: _____ Phone Number: (____) _____

Dates of Employment: _____ Work hours: _____

If less than 2 years, prior employer: _____

Work Supervisor: _____ Phone Number: (____) _____

Dates of Employment: _____ Work hours: _____

On a separate sheet of paper, describe your present professional practice.

Please arrange for your supervisor to submit a letter summarizing your job duties, job performance and any information the employer has regarding the event that resulted in your referral to PAP.

TREATMENT

Current treatment facility: _____

Address: _____
Street

_____
City State Zip Code

Name of therapist: _____
Last First Middle

Phone number: (_____) _____

Submit a copy of a current assessment (completed within the last 6 months), discharge summary and aftercare plan.

On a separate sheet of paper, list all treatment programs you've completed in the past (provide dates of each).

Do you attend AA/NA or other self-help groups? _____ Yes _____ No How many per week? _____

Do you have a sponsor? _____ Yes _____ No How many contacts per week? _____

Do you acknowledge your need for treatment for chemical dependency? _____ Yes _____ No

Why or why not? _____

_____

_____

OTHER

List all other states in which you hold licenses to practice: _____

Are you or have you been subject to drug and/or alcohol monitoring (disciplinary or non-disciplinary) in this state or any other? ____ Yes ____ No
If yes, provide a copy of the consent order/contract and written verification of your compliance or successful discharge.

Are you currently, or have you ever been subject to any criminal proceedings in this state or any other? ____ Yes ____ No
If so, describe all actions in detail on a separate sheet and submit relevant records

Are you currently, or have you ever been subject to any civil suits in this state or any other? ____ Yes ____ No
If so, describe all actions in detail on a separate sheet and submit relevant records

If you self-reported to PAP, are you aware of whether your employer or anyone else has or intends to file a complaint against you? ____ Yes ____ No

On a separate sheet of paper, explain the circumstances <u>in detail</u> that brought you to the PAP.

I, the above-named applicant, affirm that all the statements contained herein are strictly true in every respect. I hereby authorize the PAP Coordinator and/or PAP Liaison to conduct an investigative background check regarding the information I provided in my application. I understand that any false, omitted or misleading information in, or in connection with, my application may lead to the denial of my application, dismissal from the PAP, and/or disciplinary action against my license.

Signature _____ Date _____

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PROFESSIONAL ASSISTANCE PROCEDURE (PAP)

AUTHORIZATION FOR RELEASE OF INFORMATION

Participant's Name: _____ Participant's Date of Birth: _____

I, _____, hereby authorize the Wisconsin Department of Safety and Professional Services (Department), PAP Coordinator and PAP Liaison, to discuss my application and participation in the PAP with my physician, treatment provider, current, former, or prospective employer, supervisor and/or professional mentor. This includes, but is not limited to, the conduct relating to my application and participation in the PAP pursuant to Wis. Admin. Code § SPS 7.05(1)(g), my treatment progress, my drug and alcohol test results, my work performance and my overall compliance with the PAP. A reproduction copy of this Authorization Form shall be as valid as the original.

This disclosure is being made for the purposes of monitoring my participation in the PAP. The validity of this consent shall run concurrent with the validity of the Agreement for Participation in the PAP. I understand that: (a) it is my responsibility to sign and furnish the PAP Coordinator with all consents for release of information complying with state and federal laws authorizing release of reports to and from my physician, to and from my treatment provider, to and from facilities conducting drug screens and to and from my employer in compliance with the requirements of Wis. Admin. Code § SPS 7.05; (b) the information obtained as a result of this consent may be used after the expiration date if I am dismissed from PAP under Wis. Admin. Code § SPS 7.04 (2); and (c) the information that the Department receives under this request will not be re-disclosed except in the case of a Department or board proceeding, or a valid open records request and then only under the circumstances permitted by law and re-disclosed information is no longer protected by privacy laws.

Signature: _____ Date_____

Print Name: _____