Texas Physician Health Program
Work Site Monitor (WSM) Report Form

All records and information maintained by the TXPHP are confidential under Sec. 167.010 of the Medical Practice Act, and other state and federal statutes protecting patient and TXPHP participant privacy and are not subject to disclosure.

Re: _____ _____
Name of TXPHP Participant TXPHP #

Date: _____

WSM Name and Title:
_____

Participant employer/organization: _____

WSM professional relationship with the participant:
_____

Address: _____

City, State, Zip: _____

Phone #: _____ Email:_____

Please fill out this form completely and accurately. Do not leave any question blank.

1. **I have had (insert number) _____ personal interactions with the individual in the last three months.**
2. **I have observed changes in the individual's attendance.** Y☐ N☐

   If yes, please explain _____.
3. **I have observed changes in the individual's personal habits**. Y☐ N☐

   If yes, please explain _____.
4. **I have observed changes in the individual's practice performance.** Y☐ N☐

   If yes, please explain _____.
5. **I have observed changes in the individual's interpersonal relationships.** Y☐ N☐

If yes, please explain _____.

6. **I have observed changes in the individual's social behavior.** Y☐ N☐

   If yes, please explain _____.

7. **I have observed changes related to the individual's use of prescription and/or non-prescription drugs or alcohol.** Y☐ N☐

   If yes, please explain _____.

8. **I am aware of the individual facing significant professional/personal challenges this month.** Y☐ N☐

   If yes, please explain _____.

9. **In my opinion, the individual's overall performance is satisfactory.** Y☐ N☐

   If no, please explain _____.

10. **I have concerns about the individual's workplace performance.** Y☐ N☐

    If yes, please explain _____.

11. **I have additional information to provide.** Y☐ N☐

    _____.

Please indicate if you would like for the TXPHP Medical Director to call and speak with you about this participant: Yes ☐ No ☐

Individual that the Medical Director should contact: _____

Dates/times available: _____

Phone: _____ Day of week and time: _____

Email: _____

Select one of the following:

[ ] I swear and affirm that my relationship with the TXPHP participant is solely for the purposes of our shared employment or professional healthcare relationship, as specified above, and through my relationship as a worksite monitor and is limited to these relationships only. I am not in any way related to the participant, nor do we have a personal relationship of any kind, a professional healthcare-related relationship of any kind outside of the professional healthcare relationship pursuant to my role as a worksite monitor, a business or financial relationship of any kind, or any other relationship that may present an ethical or professionalism issue.

[ ] I have a relationship with the TXPHP participant beyond our shared employment or professional healthcare relationship, as specified above, and through my relationship as a worksite monitor.

Describe all other relationships with the TXPHP participant. [text box for description]

This report is an accurate evaluation of the individual's work site performance, includes any observed behavioral changes (positive or negative) and is submitted with the individual's consent to monitoring.

Electronic Signature: _____