UPHP

Prescriber/Primary Care Physician Acknowledgment of Participation

PARTICIPANT SECTION

I, (print name) _____ have informed the provider below that I am a participant of the Utah Professionals Health Program. UPHP is a confidential health program.

_____ I have informed my prescriber that I have substance use disorder.

_____ I have asked my prescriber to not prescribe nor administer any mood-altering or potentially addicting medication unless there is no reasonable medical alternative.

_____ Should such medications become necessary, I would like my provider to help create a safety plan.

_____ I have informed my prescriber that if I am prescribed certain controlled substances that I must withdraw from practice until 24 hours after my last dose.

PRIMARY CARE SECTION

I, (print name) _____ acknowledge that

_____ is a participant in the UPHP and that they have informed me that they have a Substance Use Disorder. The participant and I have discussed all topics above.

SIGNATURE

Prescriber Signature:_____ Date: _____

Participant Signature:_____ Date: _____

Please email to UPHP@Utah.gov. If you have questions or concerns, please call 801-530-6428.