IBH POPULATION HEALTH SOLUTIONS
MONITORING

Health Professionals' Services Program Workplace Monitor Safe Practice Report

HPSP requires the following safe practice report form be completed by the workplace monitor and that the form be sent directly to IBH HPSP. **This form must be submitted on a monthly basis in order for the Licensee to be in compliance with his/her monitoring agreement. Please either mail or fax this form to IBH by the close of business on the 5th day of each month. If in between the reporting time period there is any evidence of unsafe job performance or any concerns please contact IBH immediately at 1-888-802-2843. This is a confidential document and only should be viewed by staff with a need to know.**

Licensee Name or account#: _____ Evaluation From: _____ To: _____

Employment Setting:
Name of Employer: _____ Workplace setting: _____
Name of Workplace Monitor: _____ Telephone: _____
Confidential fax_____ Email address:_____

Job Specifications:
Has there been a change in the licensee's position or job description since the last report? (Check One) yes no
Current Position Title: _____ Start date if new position: _____
Work Hours/Shift: _____
Frequency of contact w/ Licensee: (Check One) daily, twice a week, weekly, every other week, monthly

Physical performance • Balance • Manual coordination/tremor • Speech patterns • Gait/stance	**Within acceptable limits for workplace** Yes or No
Cognitive performance • Mental alertness/concentration • Memory • Accuracy of documentation	**Within acceptable limits for workplace** Yes or No
Communication performance • Emotional tone with co-workers and patients • Response to feedback on performance • Maintenance of clear professional boundaries	**Meets Worksite Standard** Yes or No
Attendance • Consistent attendance without change in pattern • No unexplained absences	**Meets Worksite Standard** Yes or No
Management of Worksite Medications, if applicable • Medication administration/documentation consistency • Adherence to narcotic disposal policy • Authorized access to controlled medication	**Meets Worksite Standard** Yes or No NA

Please describe any behavioral changes since last report:

Comments including any concerns expressed by others pertaining to the licensee's practice:

Would you like to speak with the licensee's agreement monitor? (Check One) Yes No

Paste Image of Signature Here: **OR Type Name Here in Lieu of Signature :**_____ **Date:** _____

Print Name: _____ **Title:** _____

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