Professional Monitoring Inc.

Assistance Agreement

Professional Monitoring Inc. (PMI) specializes in monitoring individuals with substance-use disorders. Monitoring improves outcomes, especially when there is a contingency agreement, such as this, that delineates consequences of relapse. This agreement therefore will strive to objectively document successful recovery, detect relapse early, should it occur, and defines the consequences of relapse. The overall goal is to promote accountability and successful outcomes.

Please review this agreement, initial every paragraph, and send the completed form to 121 10th St NW, Rochester, MN 55901-6843 or scan and email it to shannonskipper@professionalmonitoring.com.

Last Name:_____ First Name:_____ DOB:_____ SSN: _____

Addresses

Home:_____
Street Address City State Zip

Office:_____
Street Address City State Zip

Other: ( ) _____
Street Address City State Zip

Other: ( ) _____
Street Address City State Zip

Phones, etc.

Home Phone: (___)_____ Office Phone: (___)_____ Beeper: (___)_____

Mobile Phone: (___)_____ Fax: (___)_____ Other ( ): (___)_____

Email Address: _____ Date: _____

*(Please place an asterisks beside preferred telephone number. Mail will be sent to your home address marked "Confidential and Personal" unless otherwise indicated by you.)

Significant other or emergency contact: Name:_____ PHONE:_____

Term of Agreement

1. I, _____, agree to the terms of this agreement for a **period of ____ months/years** from the date of this agreement. Alterations cannot be made without prior approval from my case manager or medical director. Failure to adhere to the terms of this agreement will result in a report being made to my Accountability Team (see below). This contract can be extended as needed. _____(Initials)

Toxicology Testing

2. I agree to **abstain** from any and all potentially addictive chemicals, at all times, unless prescribed by a licensed physician who is aware of my substance abuse problem. If medication is prescribed, I will provide evidence, in advance, except for emergencies, documenting this fact, by either faxing a copy of my prescription or a note from my doctor. If the need for the medication is ongoing, I will renew verification every 90 days.

   Unless appropriately prescribed I will abstain from any and all addictive drugs including:

   All scheduled drugs, including but not limited to:
   Marijuana,
   Tranquilizers,

Sedatives,
Stimulants,
Narcotics,
Opioids,
Sleeping pills,
Androgenic steroids,
Unscheduled addictive drugs, including but not limited to:
Alcohol (ie ethyl alcohol or ethanol),
Nubain,
Ultram (tramadol),
Butalbital,
Etc.

I agree to avoid exposure to anything that will cause my urine drug test to be positive. In that regard I will avoid such items as "hemp oil" or "coca tea" and I will not consume poppy seeds (which can be found in curry sauces, breads, salad dressings, and in or on other foods). I will not associate or remain in the vicinity of anyone smoking marijuana. I will not use ethyl alcohol in any form (including alcohol "free" wine or beer, over-the-counter drugs containing alcohol (cough syrup, Nyquil or other similar OTC drugs or supplements), mouthwash or other hygiene products containing ethanol, foods containing ethanol (desserts, vanilla extract, etc), communion wine, sanitizing hand or body gels (Purell or other), or any other form of ethyl alcohol). Intentional use of any of these products or medications without a physician's order is a violation of this agreement.
_____(Initials)

3. I will submit to **toxicology screening** of urine/blood/sputum/hair/nails (usually urine) as requested. These screening tests will be random and observed. I will participate in random testing at least 3-5 times per month. At some point, based upon recommendations, my screening may be reduced to 11-13 per year thereafter for the duration of this agreement. I understand that testing is truly random and can occur at any time. I agree to adhere to the urine testing notification and collection procedures and protocols.

   I agree to check-in online at www.aosintl.com/pmi or call the 800 number provided on a daily basis, Mon – Fri, as directed. I understand my compliance with check-in is monitored and that if I fail to check-in on a given day, additional tests will added. I further understand that if the notification system fails or I do not receive notification to provide screening tests, within a reasonable period (e.g. approximately 3 times my usual testing frequency) it is my responsibility to notify the program. I further understand that if I am instructed when I check-in to provide a sample and I do not provide a specimen on the day of notification it will be considered a **positive** test. _____(Initials)

4. Accountability Team: The following should be notified if I fail to check-in, show up for a test, or have an unexplained positive test. I agree to notify each of these individuals regarding my recovery and participation in PMI drug testing.

List of people to notify if there are problems	Phone numbers
_____	_____
_____	_____
_____	_____
_____	_____

____ (Initials)

_____
Signature Date

_____
Printed name