Washington State Department of Health
Washington Health Professional Services
PO Box 47872
Olympia, WA 98504-7872

WHPS-1

Monthly Self Report

Reporting Month From: To:	Report Due at WHPS Office by the 5th of Each Month

Name | Phone #:

Address

City | State | Zip Code | Check here if new address ☐

Have you changed your name? (If yes, provide new information in the spaces above.) ..... ☐ Yes ☐ No

Are you currently working in Health Care? ..... ☐ Yes ☐ No

Work Site Monitor Information:

Name of Current Work Site Monitor

Address

City | State | Zip Code | Phone Number ( )

Have you had a change in employment? (If yes, provide details under **additional comments.**) ..... ☐ Yes ☐ No

Name of New Employer

Address

City | State | Zip Code | Phone Number ( )

Have you had a change in therapist(s)? ..... ☐ Yes ☐ No

Therapist's Name | Therapist's Telephone Number ( )

Address

City | State | Zip Code

Which support group are you attending?	Name of Facilitator	Day of Week

How many AA/NA meetings are you attending? Who is your sponsor?

Unavailability dates: _____

Forms are available from our website: https://fortress.wa.gov/doh/hpqa1/hps2/WHPS/forms.htm

Please respond to the following topics in detail, using additional sheets of paper if necessary.

I. Stressors currently in your life and your method(s) of handling _____

_____

_____

_____

II. Use of any drugs: _____

_____

_____

_____

III. Handling of controlled substances in work situation:

IV. Mental and/or physical health:

V. Counseling/Treatment activities and progress:

VI. Professional activities/Continuing education:

VII. Personal activities/Support systems:

VIII. How are you abiding by the terms and conditions of your contract?

Additional Comments:

Signature

Date