

**NEW HAMPSHIRE
PROFESSIONALS HEALTH PROGRAM**

**Sally J. Garhart MD
Medical Director**

**P.O. Box 6274
Amherst, NH 03031
(603)- 491-5036
FAX (603) 924-0161**

CONFIDENTIAL REPORT

Therapist / Treatment Provider

NH PHP Participant: _____ **(NAME must be filled in)**

This provider has authorized you to complete quarterly reports regarding compliance with his/her contract with the New Hampshire Professionals Health Program. Accurate and prompt information from treatment providers is essential to provide assurance that this provider is continuing his/her treatment and practicing without impairment. Please notify the NHPHP immediately if therapy is terminated.

If you have any questions, please contact Sally J. Garhart, MD Medical Director or Deanne Chapman, PA-C Assistant Director.

Quarter ending: please circle March 31 June 30 September 30 December 31

1) During the past three months, I have met with this provider:

Number of sessions _____ at a frequency of _____.

Have the appointments been frequently cancelled, rescheduled or missed? Yes ___ No ___

Details _____

2) Is there any evidence of non-compliance with treatment and/or medication ? Yes ___ No ___

Detailed concerns or comments: _____

3) What other referrals or treatments are planned? _____

4) Do you have any concerns regarding his/her ability to safely practice medicine? Yes ___ No ___

Details _____

5) Would you like the NH Professionals Health Program Director to call you? ___No ___Yes

(phone no. _____)

Provider name

Signature

Date

Address _____ **Telephone** _____