

### **Behavioral Sciences – Licensee Self-Report**

Complete and submit this report to your Compliance Case Manager (CCM) as required by the terms of your order. This report must be received by your CCM from 5 days before until 5 days after the end of the current quarter (e.g., if report is for the quarter ending 3/31, send between 3/26 and 4/5). You may submit this form to your CCM via email, mail, fax, or hand delivery.

Period covered under this report (complete year and check appropriate quarter):

Year: \_\_\_\_\_

Quarter:

☐ Jan–Mar

☐ Apr–Jun

☐ Jul–Sep

☐ Oct–Dec

#### **Current Personal Information**

Name: \_\_\_\_\_

Address (include city, state, zip): \_\_\_\_\_

\_\_\_\_\_ This is a change of address, and I want this to be changed with the Board as my address of record.

Phone: (cell) \_\_\_\_\_ (work) \_\_\_\_\_ Email: \_\_\_\_\_

Do you hold a health or mental health license, certificate, or registration in Virginia or any other jurisdiction? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, provide details (state or national entity, license type, etc.) \_\_\_\_\_

#### **Current Employment Information (list all additional current employment information as a separate attachment)**

Agency/Company Name: \_\_\_\_\_ Date Employment Began \_\_\_\_\_

Address (include city, state, zip): \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

If required, was this supervisor approved by the Board? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ n/a

Does this position require you to maintain your license/certificate/registration? \_\_\_\_\_ Yes \_\_\_\_\_ No

Job Duties: \_\_\_\_\_

Has your employment changed since the last quarter report? \_\_\_\_\_ Yes \_\_\_\_\_ No

**If yes, complete the following:**

Former Agency/Company Name \_\_\_\_\_ Termination Date \_\_\_\_\_

Reason for termination or resignation: \_\_\_\_\_

#### **Treatment Information**

Did you attend any recovery programs during this quarter? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, provide details (type of program, duration, etc.) \_\_\_\_\_

Did you attend therapy sessions during this quarter? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, provide details (individual/group, name of therapist, frequency of visits, etc.) \_\_\_\_\_

Were you required to complete drug screenings during this quarter? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, provide a copy of the results of the screenings.

Have you taken or been prescribed any medications during this quarter? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, list the drug(s) and prescriber(s) \_\_\_\_\_

#### **Arrests and Convictions**

Have you been arrested, convicted, or have any pending charges in any court during this quarter? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, provide details (charge/conviction, court, date, etc.) \_\_\_\_\_

Has any regulatory board in any state notified you of pending action or investigation against you? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, provide details (state, board, license type, etc.) \_\_\_\_\_

\_\_\_\_\_  
Signature of Licensee

\_\_\_\_\_  
Date