



**CONFIDENTIAL**  
**APPLICATION FOR VOLUNTARY TREATMENT OPTION PROGRAM**  
**(A Professional Assistance Program)**  
**Pursuant to 29 Delaware Code, Section 8735(n)**

**As a condition for entry into the VTO program, the applicant can not have committed any offense(s), other than the status of being chemically dependent or impaired which otherwise constitutes a ground for discipline under applicable laws governing my regulated profession.**

LICENSING BOARD: \_\_\_\_\_

CASE # \_\_\_\_\_

**CONFIDENTIAL**

**APPLICATION FOR THE VOLUNTARY TREATMENT OPTION PROGRAM  
(A Professional Assistance Program)**

**INTRODUCTION**

By submitting this application, I request approval to participate in the Voluntary Treatment Option (VTO) for chemically dependent or impaired professionals provided for by 24 Del. C. §8735(n). **I hereby certify as a condition to entry into the VTO program that I have not committed any offense(s), other than the status of being chemically dependent or impaired which otherwise constitutes a ground for discipline under applicable laws governing my regulated profession.**

By submitting this application, I agree that I will:

1. Voluntarily submit to a drug and alcohol screening, evaluation, and assessment at my expense at a specified laboratory or health care facility agreed upon by me and by the Director of the Division of Professional Regulation (DPR) and the chairperson of my State of Delaware professional licensing board or their designees.
2. Voluntarily enter into binding contracts for treatment and monitoring by a different laboratory or health care facility at my own expense. Such contracts must be acceptable to me and to the Director of DPR and the chairperson of my professional licensing board or their designees. Such contract will provide for consent to release to the licensing board designee and the Director of Professional Regulation or his or her designee, information concerning my participation in the VTO program. Such consent is a condition of my admission to the VTO program.
3. Voluntarily comply with any and all restrictions and conditions imposed on my professional practice by the Director of DPR and the chairperson of my professional licensing board as specified in my contract for treatment and monitoring or any amendments thereto as directed by the Director of DPR and/or the chairperson of my licensing board or their designees. I specifically understand and agree that:
  - A. My records of participation in the Voluntary Treatment Option program will not reflect disciplinary action and will not be considered public records, but that my participation in this program may be reported to other State’s Board of Nursing.
  - B. My participation in the Voluntary Treatment Option program does not shield or protect me from disciplinary action for professional misconduct either before or after my application for or acceptance in the program
  - C. Results from any drug testing performed after acceptance into the VTO program may be used for license disciplinary proceedings.

Date: \_\_\_\_\_

\_\_\_\_\_  
Applicant Name (printed)

Signature

LICENSING BOARD: \_\_\_\_\_ CASE # \_\_\_\_\_

**APPLICATION FOR THE VOLUNTARY TREATMENT OPTION PROGRAM  
(A Professional Assistance Program)**

**Incomplete applications will not be considered. All blanks must be completed with responses or N/A.**

NAME: \_\_\_\_\_ LICENSE TYPE: \_\_\_\_\_

LICENSE NUMBER: \_\_\_\_\_ YEARS LICENSED: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ SUPERVISOR: \_\_\_\_\_

PHONE: \_\_\_\_\_

LIST ANY OTHER CURRENT EMPLOYER(S): \_\_\_\_\_

1. I am requesting admission into the VTO Program for the treatment of my chemical dependency. Specifically:

a) \_\_\_ Excessive drug use (specify drug(s) of choice) that lead to impaired functioning.

b) \_\_\_ Excessive alcohol use/addiction that lead to impaired functioning.

Please write a brief narrative describing your experience with the chemical(s) noted above.

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2. In what other states have you been licensed? \_\_\_\_\_

3. List all states in which you are practicing. \_\_\_\_\_

4. Have you ever participated in a drug or alcohol Diversion Program or a similar program in

any state? No\_\_\_\_\_ Yes\_\_\_\_\_

If no, please proceed to question 6.

Location(s) \_\_\_\_\_

Dates of participation (if more than one, give dates for each time) \_\_\_\_\_

\_\_\_\_\_

Contact Person(s) \_\_\_\_\_

5. Have you ever been terminated from or failed to complete any drug or alcohol Diversion Program? No\_\_\_\_\_ Yes\_\_\_\_\_

6. Have you ever been placed on probation or had Board action taken against you by any licensing board in the past? No\_\_\_\_\_ Yes\_\_\_\_\_

State(s) \_\_\_\_\_

Date(s) \_\_\_\_\_

What was the violation? \_\_\_\_\_

7. Has your professional license ever been suspended, revoked, relinquished, or probated? No\_\_\_\_\_ Yes\_\_\_\_\_

State(s) \_\_\_\_\_

Date(s) \_\_\_\_\_

What was the violation? \_\_\_\_\_

8. Has your driving license ever been suspended, revoked, relinquished, or probated for a drug related or alcohol related incident? No\_\_\_\_\_ Yes\_\_\_\_\_

If yes, please provide a certified copy of your driver's license record.

State(s) \_\_\_\_\_

Date(s) \_\_\_\_\_

For what violation? \_\_\_\_\_

9. Have you ever been convicted of a felony or crime involving controlled substances? No\_\_\_\_\_ Yes\_\_\_\_\_

If yes, please attach copies of the court documents.

10. Have you ever been in treatment for a drug and/or alcohol problem? No\_\_\_\_\_ Yes\_\_\_\_\_

How long was your longest period of sobriety and/or abstinence? \_\_\_\_\_

Where were you in treatment? \_\_\_\_\_

- 
- Date(s) \_\_\_\_\_
10. Are you in therapy now? No \_\_\_\_\_ Yes \_\_\_\_\_  
Therapist \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_  
What (if any) medications are you currently taking? \_\_\_\_\_
11. If you are not in therapy, what are your plans regarding therapy or recovery? \_\_\_\_\_
12. What is your practice area? (Specify areas of practice and describe direct patient/customer contact.)  
\_\_\_\_\_  
\_\_\_\_\_
13. Do you wish to continue to practice your licensed profession? No \_\_\_\_\_ Yes \_\_\_\_\_
14. Do you feel safe to practice? No \_\_\_\_\_ Yes \_\_\_\_\_  
Please explain \_\_\_\_\_
15. Have you reported your drug or alcohol problem to your supervisor?  
No \_\_\_\_\_ Yes \_\_\_\_\_
16. Do you have access to your drug of choice at work? No \_\_\_\_\_ Yes \_\_\_\_\_
17. What plans, if any, have you made to limit such access? \_\_\_\_\_
18. What are your goals for participating in this VTO program? \_\_\_\_\_
19. Does your employer know of your interest in the VTO program?  
No \_\_\_\_\_ Yes \_\_\_\_\_  
If no, what are your plans about informing your employer and when will this occur?  
\_\_\_\_\_  
\_\_\_\_\_
- 19a. Does the Director of DPR and/or the chairperson of the professional licensing board or their designees have your authorization to discuss your application with your employer?  
No \_\_\_\_\_ Yes \_\_\_\_\_

20. Does your family or significant other know of your interest in the VTO program?  
No \_\_\_\_\_ Yes \_\_\_\_\_

If no, what are your plans for informing your family or significant other? \_\_\_\_\_

21. Who in your life will support your recovery/health maintenance? (identify all) \_\_\_\_\_

I certify that all information I have provided is complete and accurate.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

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**AGREEMENT**

**In addition to the representations made above, it is understood and agreed that upon acceptance of this application by the Director of the Division of Professional Regulation and approval by the Chairperson of the licensing Board or his or her designees this shall become the agreement specified in 29 Del. C. §8735(n)(6). It is understood and agreed that the applicant will not be identified to the participating regulatory Board so long as the applicant is in compliance with the agreement and that the applicant's failure to satisfactorily progress in a treatment program shall be reported to the participating Board's chairperson or his or her designate or to the Director of the Division of Professional Regulation or his or her designate by the treating professional(s). It is further understood and agreed that the applicant's participation in this Voluntary Treatment Option program may be reported to other State's Board of Nursing. It is further understood and agreed that the applicant will be personally responsible for all costs, fees and charges associated with the Voluntary Treatment Option and treatment program(s).**

**Application: (Approved) (Disapproved)**

**State reason(s) for disapproval** \_\_\_\_\_

**Assessment facility** \_\_\_\_\_

**Treatment facility** \_\_\_\_\_

**TREATMENT AND MONITORING CONTRACTS, ONCE EXECUTED, WILL BE ATTACHED TO AND BECOME PART OF THIS AGREEMENT.**

**PRACTICE RESTRICTIONS WILL BE SPECIFIED BELOW AND MAY BE AMENDED BY FURTHER WRITTEN AGREEMENT, WHICH SHALL ALSO BE ATTACHED TO THIS AGREEMENT.**



**AUTHORIZATION TO RELEASE INFORMATION**

I, \_\_\_\_\_, hereby authorize my treating or evaluating chemical  
(Print Name)  
dependency specialist \_\_\_\_\_ to disclose any and all current and  
(Print Name)  
ongoing written and verbal information to the Director of the Division of Professional Regulation  
and/or designee and the chairman and/or his or her designee of the Board of \_\_\_\_\_.

**Check all** information to be disclosed:

- |  |   |
|--|---|
| <input type="checkbox"/> Intake summary                        | <input type="checkbox"/> Progress reports     |
| <input type="checkbox"/> Treatment plan                        | <input type="checkbox"/> Discharge summaries  |
| <input type="checkbox"/> History and physical exams            | <input type="checkbox"/> Diagnosis, prognosis |
| <input type="checkbox"/> Monitored Antabuse/Naltrexone report  | <input type="checkbox"/> Performance reports  |
| <input type="checkbox"/> Urinalysis or other chemistry reports | <input type="checkbox"/> After Care reports   |
| <input type="checkbox"/> Other _____                           |   |

The purpose of this disclosure is to coordinate the rehabilitation process with the Regulatory Licensing Board pursuant to the Voluntary Treatment Option (VTO) under 29 Del. C. §8735(n).

This information will be disclosed from records whose confidentiality may be protected by federal law. Federal regulations (42 CFR Part 2) prohibit any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. This general authorization for the release of medical or other information is not sufficient for this purpose.

If a licensee is accepted into the VTO Program and has a signed Diversion Program Contract, this consent will terminate upon completion and/or termination of the VTO Program Contract. This authorization is subject to revocation at any time except to the extent that the program that is to make the disclosure has already taken action in reliance on it. Revocation of this consent will be reported to the Director of the Division of Professional Regulation for determination of noncompliance with the VTO Program, which may be reported to the State Licensing Board. A copy of this document will have the same force and effect as the original.

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

\_\_\_\_\_  
Witness Signature

Date: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date Accepted into VTO Program  
(This document is only valid if licensee is accepted into program.)

