ERIE - ST. CLAIR CLINIC
CENTRE OF EXCELLENCE IN ADDICTIONS MEDICINE

CADUCEUS PROCESS

Erie St Clair Clinic
1574 Lincoln Rd, Windsor, On N8Y 2J4
Tel: 519-977-9772 **Fax:** 519-977-7145

NEXT STEPS:

• DO NOT resign your position at work and DO NOT voluntarily surrender your license to practice. Find out if your employer has in fact reported you and/or will be reporting you to your College. **Stop practicing immediately.**

• If you are a **Union** employee (ie ONA/Unifor), follow up with your Union Representative and the Union's legal team for further instruction regarding representation of your case to your employer and College.

• Request a medical leave of absence from your employer if one hasn't already been offered i**mmediately** and if your place of employment offers **EAP** (Employee Assistance Program) Counselling Services, make an appointment with a Therapist as soon as possible.

• Make an appointment to see your Family Physician as soon as possible and bring the proper **medical certificate** documentation required by your employer for your requested medical leave of absence.

• Make an appointment with an **Addiction Specialist** as soon as possible to start urine toxicology sampling by contacting **intake** at the Erie St. Clair Clinic on Lincoln Rd. in Windsor at 519-977-9772). ***(This start date will prove significant to yourself and your College in the future).***

• Contact **Substance Abuse Treatment** facilities and/or programs in the area/region of which you are prepared to attend/participate. (Of note, healthcare professional Colleges tend to prefer and may even mandate inpatient, residential treatment programs, although some may accept outpatient).

• Seek information and support from knowledgeable, experienced healthcare professionals by attending the monthly **Windsor Caduceus Group** meetings immediately.

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WHAT TO EXPECT:

• Be prepared to be off work for **a minimum of six months** however **DO** expect to return to your career!

• Be prepared to receive notice from your College that they are **conducting an investigation regarding your competency to practice.** ***(Do not speak directly with your College if you have Legal Representation provided by your Union (ie: ONA/LEAP).***

• Be prepared to see your **Addiction Specialist and Family Physician frequently. Keep your appointments, keep up with your urine sampling, remain abstinent of any/all substances including alcohol and continue to seek treatment, resources and support including attending monthly Caduceus meetings** in your area ***immediately.***

• Be prepared to enroll into and successfully complete an inpatient **residential treatment program** for up to 45 days as soon as possible, followed by ongoing post completion recovery treatment and support.

• Be prepared to find up to a six-month **waiting list** for inpatient treatment options. (Private pay beds are available in some facilities which may expedite admission; some insurance companies may cover a portion).

• Be prepared to follow a monitoring agreement between your Addiction Specialist, yourself, and your employer to **expedite** your return to work if your College is delayed in their investigation process.

• Be prepared to attend **additional** Addiction Specialist and Psychiatric evaluations as required by your College which may include some travel. (This can be a lengthy and frustrating process, seek support from knowledgeable resources such as the Windsor Caduceus Group).

• Be prepared to agree to an **undertaking** with your College with provisions on your license to practice upon your return to work. These provisions may last up to **five years** from your identified start date.

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ERIE ST CLAIR CLINIC – WINDSOR CADUCEUS GROUP
Monitoring Agreement

I, _____ want and agree to participate in the Windsor Caduceus Group. In doing so, I voluntarily agree to all of the following terms and conditions of this Monitoring Agreement so that I may safely and responsibly return to work:

1. **ADVANCED APPROVAL OF EMPLOYMENT:** I will obtain approval from Dr. _____ of my conditions of employment or changes in employment. This may include restrictions on practice setting, supervision, work hours, and access to controlled substances. I will provide my prospective employer(s) with a copy of this agreement prior to accepting a position.

2. **CONTROLLED SUBSTANCES:** I will not obtain, possess, prescribe, dispense, and/or administer controlled substances.

3. **PLACE OF EMPLOYMENT:** I will return to practice at a date yet to be determined and approved by Dr. _____ .

4. **WORKPLACE MONITORING:** I will practice my profession only under the supervision of _____ at _____ who is knowledgeable of my history. He/She will report to Dr. _____ as required in this agreement. In the event I am unable to comply with the minimum standards of acceptable and prevailing practice or appear unable to practice with reasonable safety, my Workplace Monitor will immediately notify Dr. _____ .

5. **HOURS OF PRACTICE:** I will practice my profession from 0700-2400 only, not for more than twelve hours per shift, and not more than _____ hours per week unless otherwise approved by Dr. _____ . If I have been approved to work twelve hour shifts, I will not work more than two consecutive twelve hour shifts.

6. **ABSTENTION FROM MOOD-ALTERING SUBSTANCES:** I will practice total abstention from alcohol, controlled substances, and other mood-altering substances. I will notify all treating Practitioners of my Substance Abuse Disorder. In the event I am hospitalized or otherwise require medical or dental treatment involving mood-altering or controlled substances as

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ordered by my treating Physician, or Dentist, I will immediately report this fact and all relevant circumstances to my Addiction Specialist, Dr. _____ as soon as reasonably possible.

7. **12 STEP MEETINGS/SPONSORSHIP:** I will seek support from community resources including NA, AA, Women for Sobriety, ***and/or*** from Evidence Based Support Groups such as Caduceus. NA/AA meetings/sponsors ***are not required*** if attending Caduceus.

8. **CADUCEUS:** As a participant in the Windsor Caduceus Group, I understand it is required that I participate in monthly meetings. I will discuss this with my Therapist and Addiction Specialist and follow their recommendations for frequency and documentation accordingly.

9. **RANDOM URINE SAMPLING:** I submit to urine, blood, and/or hair follicle drug screens as requested by Dr. _____. Notice is hereby given and acknowledged that ingestion of any food or food supplements (herbs, poppy seeds etc.) may show a positive test for restricted drugs. Accordingly, I agree that no claim shall be made, and _____ will accept no claim, that the presence of drugs in my blood or urine resulted from consumption of such food or food supplements. I understand that missed urine screens regardless of the reason is unacceptable. This includes family emergencies, funerals, etc. If an emergency occurs, I understand I must notify Dr. _____ as soon as possible.

10. VACATIONS: If a vacation of other absence from my home area is planned, I must discuss my recovery plan to assist in maintaining abstinence, which may include drug screens with Dr. _____ .

11. **TREATING PRACTITIONERS:**

NAME	SPECIALTY	PHONE NUMBER
	Family Physician	
	Addiction Specialist	
	Psychiatrist	
	Therapist	

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If any of my treating Practitioners find I am not substance free, or have not been compliant with this agreement, or am unable, for any reason, to practice my profession with reasonable safety, he/she will notify Dr. _____ immediately in writing and provide all related information, including copies of any urine/blood drug screen results. Following the initial visit, the Addiction Specialist and Psychiatrist will determine and specify the frequency of my visits. I will continue to see all my treating Practitioners as per their recommended frequency and will **not stop** seeing any of my treating Practitioners without notification to Dr. _____ . I will provide a copy of this agreement to all of my treating Practitioners as soon as possible.

12. **MEDICATION MANAGEMENT**: I will take only those medications prescribed for me by my treating Practitioners and will notify Dr. _____ of all prescribed and non-prescribed medications I am taking. I will notify Dr. _____ and coordinate all medications prescribed to me by my treating Practitioners with him/her.

13. **THERAPY:** I will participate in group, individual, and/or community program therapy approved by Dr. _____ for a minimum of two years. If my Therapist finds I am not substance free, or have not been compliant with this agreement, or am unable for any reason, to practice my profession with reasonable safety, my Therapist will notify Dr. _____ immediately in writing and provide all related information.

14. **PROFESSIONAL COLLEGE'S MONITORING PROGRAM:** I understand it is recommended that I participate in my professional College's monitoring program if one is made available to me (i.e. undertaking).

15. **ADDITIONAL EVALUATION AND/OR TREATMENT:** I agree to submit to an independent Addiction Specialist and/or Psychiatric evaluation and/or engage in additional monitoring and/or treatment as determined by Dr. _____ .

16. **COSTS:** I accept responsibility for payment of all costs incurred in complying with the terms of this agreement.

17. **SUCCESSORS:** I will immediately provide copies of this agreement to my Workplace Monitor(s), Treating Practitioner(s), Therapist(s), and any other individual(s) involved in my care. If I wish to change employers, Workplace Monitor(s), Treating Practitioner(s), and/or

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Therapist(s), I will first obtain the written approval of Dr. _____ and will provide copies of this agreement to each successor, Treating Practitioner(s), Therapist(s), Workplace Monitor(s), and any other individual(s) required to report to Dr. _____. I will ensure compliance by providing any successor with the reporting requirements of this agreement.

18. **AUTHORIZATION FOR RELEASE OF INFORMATION:** I give Dr. _____ authorization to discuss my case with my other treating Practitioners as identified in this agreement.

19. **MODIFICATIONS TO THIS AGREEMENT:** I understand and agree that Dr. _____ may at his discretion, modify the terms of this agreement as necessary to protect the public health, safety, and welfare and/or to facilitate my progress in recovery. All modifications will be reflected in an addendum to this agreement signed by Dr. _____ and myself. My failure to agree to and/or comply with modifications as determined by Dr. _____ may be considered a breach of this agreement.

20. **VARIATIONS TO THIS AGREEMENT:** Any requests I make for variations in this agreement (i.e. lifting of restrictions etc.) must be in writing, accompanied by supporting documentation, discussed with, and approved by Dr. _____ .

21. **EMPLOYMENT:** Failure to abide by the terms of this agreement may result in my being asked to refrain from working until my ability to practice safely has been re-established. In the event that my Workplace Monitor is unavailable, I will be asked to identify an appropriate alternate and agree to sign a release of information to that person.

22. **EXPIRATION OF AGREEMENT:** Successful completion of this Monitoring Agreement will require a minimum of 3 years of documented abstinence as determined by negative urine drug screens and/or alternate methods (including hair sample analysis) as recommended by Dr. _____ . A positive confirmed urine drug screen during the last year of the Monitoring Agreement will result in the extension of the agreement for an additional two years after the last positive test.

23. **REPORTS TO THE COLLEGE:** I understand that Dr. _____ is required by law to notify my College if I do not comply with this Monitoring Agreement. In such case, I authorize Dr. _____ to disclose the circumstances of my impairment and failure to comply for the safety of the public.

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24. **VIOLENCE:** I understand any threats or acts of violence or harm toward Dr. , Erie St. Clair staff members, members of the Windsor Caduceus Group, and/or anyone involved in the program may result in immediate dismissal from the program.

25. **SIGNATURES:**

Patient		**Date**	
Addiction Specialist		**Date**	