



The Commonwealth of Massachusetts  
Department of Public Health  
Bureau of Health Professions Licensure

**Board of Registration in Nursing**  
239 Causeway Street • Boston, Massachusetts 02114

Substance Abuse Rehabilitation Program  
**CASP Amendment Request**

Name of SARP Participant (please print) \_\_\_\_\_

Date original Consent Agreement for SARP Participation (CASP) signed by the Board Executive Director \_\_\_\_\_

Sobriety date \_\_\_\_\_

**Proposed Amendment /Change to CASP**

**Change from:** \_\_\_\_\_

**Change to:** \_\_\_\_\_

Rationale for Change: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe the progress in your recovery that supports this change: \_\_\_\_\_

\_\_\_\_\_

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**Submitted (9) contact hours related to substance abuse prior to completing your first year in SARP** [ ] Yes [ ] No

When appropriate, please forward your therapist and/ or employer's recommendations to us regarding the requested change.

Therapist recommendation [ ] Yes [ ] No to be forwarded [ ] Yes [ ] No

Employer recommendation [ ] Yes [ ] No to be forwarded [ ] Yes [ ] No

\_\_\_\_\_/\_\_\_\_\_  
Licensee signature Date

*(Please use the reverse side for additional space, if needed)*