DPH TB PREVENTION AND CONTROL
Georgia Department of Public Health

I, _____ agree to provide Directly Observed Therapy (DOT) for the
      (name of DOT provider)
treatment of persons with tuberculosis (TB) or latent TB infection (LTBI) in order to help prevent further spread of the disease and/or infection as well as decrease the risk of developing resistance to TB medications. I understand that I will support and observe the patient with the self-administration of his/her own medication. DOT does **NOT** entail dispensing (labeling medication containers), administering (taking medication from the bottle to give to the patient), pouring or altering TB medication(s).

❑ I acknowledge that I have reviewed and received training (as outlined below) regarding the Georgia DOT Policy and Procedures manual. I have a copy of this policy and will operate under this policy every time I provide DOT for persons with TB or LTBI.

I also agree to:

❑ Adhere to the Health Insurance Portability and Accountability Act (HIPAA) and keep patient information confidential and only share the information with the patient and his/her healthcare team.
❑ Deliver the prescribed medication on the days and times as outlined in the DOT agreement (form 603) signed by the patient, myself and TB staff.
❑ Act as the patient's agent to transport his/her medication that has been prescribed and dispensed according to Georgia law.
❑ Immediately report to the TB Nurse and/or Physician any missed doses, adverse effects or any other concerns as outlined in the policy and DOT sheet.
❑ Other: _____
_____
_____

This agreement acknowledges _____ has attended and successfully
      (name of DOT worker)
completed a DOT training session conducted by _____ on _____.
      (name of TB staff)   (date)
The DOT Provider has performed _____ field visits successfully while being supervised by
      (number)
_____. The DOT provider will have supervised field visits annually
      (name of TB staff)
which will be performed by _____.
      (name/position of TB staff member)

_____   _____
DOT Provider Signature   Date

_____   _____
TB Staff Supervisor   Date