Exploring Substance Use Disorder Among Podiatric Physicians

The prevalence of addiction in the healthcare provider population has largely escaped public attention.

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Goals and Objectives

1) Understand that substance use disorder (SUD) affects healthcare professionals and recognize behavioral indicators of SUD.

2) Analyze the prevalence of SUD among specialized healthcare providers—including physicians, nurses, pharmacists, and podiatrists—through data and experiences.

3) Apply recovery resources for healthcare providers, including pharmaceutical treatments for SUD.

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*Following this article, an answer sheet and full set of instructions are provided (pg. 112).—**Editor***

Podiatric physicians must recognize that while substance use disorder (SUD) is widely reported in the media as an insidious, addictive disease, its prevalence among healthcare providers (HCPs) has largely escaped public attention—not due to immunity, but because of under-reporting. Research shows that HCPs experience SUD at rates similar to or higher than the general population.[1] Additionally, their substance use disorders are often more advanced before detection and intervention. This delayed recognition is linked to a provider's ability to maintain workplace performance and professional image long after their personal lives have deteriorated.

The primary aim of this narrative is to explore the complex, multi-faceted issue of SUD among HCPs, drawing on clinical observations, data, and best practices. First, an overview of addiction's characteristics, scope, and risks in healthcare professionals will be provided. Next, challenges in recognition, interventions, and treatment will be discussed, including the ethical and legal considerations of workplace re-integration and monitored aftercare. Finally, key findings will be illustrated through tables.

Characteristics, Scope, and Risks

The Consensus Statement on the Definition of Addiction published in

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2004 defines addiction as: "A primary, chronic neurological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: continued use despite harm (adverse consequences), impaired control over use (compulsive use), and pre-occupation with use for non-pain-relief purposes (craving)."[2]

Substance abuse and dependency affect even those who seem risk-averse, including healthcare providers. Studies estimate that HCPs misuse substances at lifetime rates of 10% to 15%, comparable to the general population.[3,4] Despite extensive training on the consequences of substance abuse, HCPs are exposed to unique professional stressors—such as clinical burnout, malpractice litigation, rising legal costs, and professional maintenance requirements—that increase their vulnerability to SUD.[4-6]

Beyond these tangible risks, HCPs also face intangible stressors, such as concerns about professional reputation, time management, and morale.[7] The manifestations of these stressors varies, making SUD recognition difficult—especially when an HCP maintains high-quality patient care and strong workplace relationships.[5] Table 1 outlines key behavioral indicators of drug addiction among HCPs.[4,5] As with all cases of SUD, early recognition and intervention are critical for successful treatment.[4] Raising awareness and fostering support systems are essential for helping HCPs achieve lasting recovery.

TABLE 1

Some Typical Signs of an Underlying Drug Addiction in HCPs Include

Withdrawal from social settings with colleagues	Heavy drinking at events
Decreased performance at work	Law enforcement troubles
Increase in time spent at work	Excessive sweating
Change in diet or appearance	Patient complaints
Frequent absences	High incidence of illness or injury
Unusual drug orders	Isolation at work
Mood swings	Slurred speech or tremors
Sexual promiscuity	Difficulty walking
Smell of alcohol	Lack of coordination
Increased anxiety, defensiveness, depression or disruptive behaviors	Memory impairment

Adapted from Berge KH, Seppala MD, Schipper AM. Chemical dependency and the physician. Mayo Clin Proc. 2009 Jul;84(7):625-31.

Any HCP can develop SUD, but high-risk factors include:

- Greater work-related stress and reliance on substances to cope.[4,8]
- Longer clinical experience and years in practice
- Working in a large medical center
- Higher-income professions, particularly in surgical and subspecialty fields.[4,8]

Among HCPs with SUD, female providers in large medical centers are at higher risk than their male counterparts.[4,8] The added pressures of gender expectations and vocational biases may compound clinical demands, but establishing direct cause and effect remains challenging.[4,8] Higher SUD rates are also observed in HCPs working in long-term care facilities, outpatient centers, and medical-surgical units.[4,9]

Additional risk factors extend beyond work setting and specialty. Career dissatisfaction and poor perceived personal health are also linked with increased SUD

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TABLE 2

News Accounts of Podiatrists and Opioid Misuse and Drug Overdose Tragedies

May 27, 2015: Dr. DLC pleaded guilty of deception to obtain a dangerous drug and illegal processing of drug documents
May 1, 2018: Dr. MJW gets over 15 years in prison for illegally distributing oxycodone
May 9, 2019: Dr. AAK has been found guilty of Federal Charges of illegally prescribing Opioid pain killers
2019: Dr. JP indictment of 38 counts of illegal processing of drug documents and 39 counts of trafficing in drugs
Feb 15, 2020: Dr. TA indicted on drug dealing charges in a crackdown on opioid prescribers and pill mills
July 21, 2021: Dr. DGS is charged with 15 felony counts of "Admin Etc Of Cont Subst By Pract"
Jan 24, 2022: Dr. DM entered a guilty pleas for unlawfully distributing controlled substances in a sex-for-drugs diversion scheme
July 01, 2022: Dr. MD admitted to his role in a healthcare fraud scheme, distribution of opioids from 2019 to 2021
March 8, 2024: Dr. SS met an untimely death from a drug overdose raising alarms and prompting investigations
March 6, 2025: Dr. PM admitted writing fraudulent prescriptions for oxycodone for her personal use

TABLE 3

Healthcare Substance Use Disorder Resources

Substance Abuse and Mental Health Services Administration. (2018). Finding quality treatment for substance use disorders https://store.samhsa.gov/product/Finding-Quality-Treatment-for-Substance-Use-Disorders/PEP18-TREATMENT-LOC
The Professionals Resource Network, Inc. (PRN) is a nationally recognized, legislatively enacted private non-profit 501 (c)3 organization. Phone (800) 488-4767. All communications with the PRN are kept in strict confidence.
Health Professional Recovery Program: Call Us (800) 453-3784; Email hprp@hprp.org
Florida's Intervention Project for Nurses (IPN) Jacksonville Beach, FL 32240-9130; Phone (800)-840-2720
SAMHSA's new National Guidance on Essential Specialty Substance Use Disorder (SUD) Care articulates a core or essential set of services for adults with SUD that should be available at any specialty SUD treatment facility in the United States. National Guidance on Essential Specialty Substance Use Disorder (SUD) Care | SAMHSA Publications and Digital Products

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vulnerability.[4,8] HCPs who feel less satisfied with their jobs and those who perceive their health as worse than that of their colleagues can provoke, perpetuate, or worsen SUD.

Common warning signs of SUD in HCPs include:

- Frequent tardiness or unplanned absences
- Patient complaints
- Increasing social withdrawal
- Documentation errors
- Carelessness in clinical decision-making
- Mood swings and erratic behavior
- Visible intoxication or physical signs of drug use
- Alcohol odor or breaths[4,10]

Historical Context

Podiatric physicians, as part of an interprofessional healthcare team, should understand the historical context of substance use disorder (SUD) in the medical profession. In 1911, Hamilton Wright, the U.S. Opium Commissioner, observed: "Of all the nations of the world, the United States consumes the most habit-forming drugs per capita."[11]

SUD has long been a problem among physicians. Dr. William Stewart Halsted, known as the "Father of American Surgery," became addicted to cocaine while experimenting with its use as a surgical anesthetic and through recreational use at "ether frolics." His subsequent treatment with morphine led to a second addiction.[12]

Each year, approximately 100,000 medical professionals experience substance or alcohol use disorders.

A 2009 study found that 50.3% of physicians enrolled in a physician health program (PHP) had misused alcohol, while nearly 36% misused opioids.[1] A 2013 study further indicated that doctors frequently abuse prescription medications to manage stress and emotional or physical pain.[13] Overall, 8% to 15% of doctors, nurses, and pharmacists have abused or misused drugs or alcohol in the workplace, with estimates suggesting that as many as 100,000 medical professionals struggle with substance or alcohol abuse in any given year.[14,15]

Healthcare professionals who practice while impaired by alcohol or other substances pose significant risks to patient safety and the reputation and financial stability of their healthcare organization.[14] While the American Medical Association (AMA) did not develop a formal policy on healthcare provider impairment until the 1970s, the issue was first documented in scientific literature as early as 1869, then referred to as "habits of intemperance."[16]

Since then, prescription drug abuse among HCPs—especially involving anesthetic and analgesic agents—has increased substantially. Physicians are five times more likely to abuse prescription drugs than the general population, with particularly high rates of benzodiazepine and opioid abuse.[16-18]

Despite the prevalence of workplace substance abuse and impairment, and its negative effects on healthcare institutions, there is limited research on effective strategies to address these problems.[14] Many HCPs operate in high-stress environments where substance use is facilitated—sometimes tacitly accepted—by a culture of tolerance, excuses, and oversight failures.[14]

Physicians' vulnerability to SUD is exacerbated by ready access to addictive substances. Studies show that alcohol, tranquilizer, and psychedelics use is higher among medical students, with dependence rates of 5% among students and 3% among doctors. The majority of substance-abusing physicians are medical graduates working in specialized fields (21%), who frequently self-prescribe medications (37%).[19]

Anesthesiologists have disproportionately high rates of opioid addiction, particularly to intravenous opioids such as fentanyl and sufentanil. Studies show that over 40% of anesthesiologists enrolled in Physician Health Programs (PHPs) were treated for IV drug use, compared to only 10% for alcohol abuse.[20-22] Estimates suggest that 10-15% of anesthesia providers will experience SUD.[20-22]

High workplace stress increases the risk of substance use disorder among anesthesia professionals.[20-22] These drugs are often diverted from the workplace, sometimes from patients.[20-22] Factors contributing to high substance abuse rates among anesthesiologists include easy access to highly addictive drugs, the ease of diversion, and a high-stress environment.[20-22] Additionally, second-hand exposure to aerosolized intravenous anesthetics may sensitize the brain's reward pathways, increasing opioid abuse risk among anesthesiologists and surgeons.[23,24]

Compared to other specialties, surgeons have lower overall substance abuse rates, except for alcohol and tobacco. A study of U.S. surgeons found high alcohol abuse and dependence rates, particularly among women (25.6%) compared to men (13.9%).[25] These numbers exceed the 6.2% prevalence of alcohol use disorder in the general U.S. population in 2019.[26]

Several reasons explain why surgeons turn to alcohol. Being a surgeon is highly demanding, where life-or-death decisions and unforeseen complications are routine, and minor mistakes can be devastating. Alcohol may be seen as a coping mechanism.

Psychiatrists are more likely to abuse benzodiazepines and are prone to stress, burnout, and suicide.[17,27] Emergency medicine physicians, who comprise only 3% of doctors, account for 7-18% of physicians in substance abuse treatment programs.[17,28,29] A recent study of emergency medicine in these programs revealed that nearly half were treated for alcohol abuse, 38% for opioids, and nearly 10% for stimulants. Emergency medicine has the highest burnout rate (60%) among medical specialties, with long shifts, high-pressure situations, and few days off.[2]

Another study revealed higher rates of illicit drug use, including marijuana.[17,28,29] Emergency medicine physicians are on the front line of care access, constantly dealing with demanding and unpredictable situations.[30] Alcohol and opioid abuse may stem from attempts to have a coping mechanism.[30]

Healthcare providers (HCPs) misuse substances at rates

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similar to the general population (10-15%).[3,4] Additionally, among dentists, substance use disorder (SUD) rates range from 12-19%, while 7-25% of pharmacists misuse non-medical prescription substances, particularly opioids and anti-anxiety medications.[31,32] The American Nurses Association estimates that up to 10% of RNs may be dependent on drugs or alcohol, with between 14-20% showing signs of drug or alcohol dependence or abuse.[33] While specific data on podiatrists is limited, about 4.4% of healthcare workers engage in heavy alcohol use.[34] It is hard to imagine anyone in the healthcare field taking illegal substances; however, approximately 5.5% struggle with illicit drug use. Table 2 outlines opioid misuse cases involving podiatrists.

Intervention and Treatment

Diagnosing SUD requires evaluating a patient's cognitive, behavioral, and physiological symptoms. It is essential to use non-stigmatizing language that respects individuals with substance use issues. Assessment may include urine drug tests and prescription drug monitoring program (PDMP) reports.[35]

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), diagnosing SUD is based on pathological behavior patterns related to substance use. Severity ranges from mild to severe, depending on symptoms categorized into four groups: Impaired Control, Social Impairment, Risky Use, and Pharmacologic Criteria (tolerance and withdrawal).

Buprenorphine acts as a partial opioid agonist at the μ-receptor and an antagonist at the κ-receptor.

No single treatment approach works for everyone. Evidence-based guidelines assist clinicians in identifying appropriate treatment options, systematically assessing patient needs to match them with the right level of care in the most appropriate setting.

Medications

Buprenorphine

Buprenorphine is the first medication for opioid use disorder (OUD) that can be prescribed in physician offices, increasing access to treatment. It should be part of a comprehensive treatment plan, including counseling and other services to provide patients with a whole-person approach. With a partial opioid agonist at the μ-receptor and an antagonist at the κ-receptor, buprenorphine has a high affinity for the μ-receptor, potentially triggering withdrawal symptoms in active opioid users.

Prescribed daily, it has a long half-life, and prevents withdrawal. Available in tablet, sublingual film, and injectable forms, many formulations contain naloxone to prevent misuse. The buprenorphine-only version is often used during pregnancy to limit fetal exposure to naloxone. Due to a "ceiling effect," doses above 24 mg do not affect respiratory or cardiovascular function.

Buprenorphine should be part of a comprehensive management program that includes psychosocial support. Treatment, however, should not be withheld even in the absence of psychosocial support. Overdose risk is lower in tolerant individuals but increases in individuals without tolerance or who are using alcohol or benzodiazepines.

Methadone is individually tailored and prescribed, frequently adjusted, and must never be shared.

Methadone

Methadone, approved by the Food and Drug Administration (FDA) for OUD and pain management, helps to sustain recovery when taken as prescribed. Methadone is safe and effective, and a key component of comprehensive treatment, which includes counseling and behavioral therapy. Methadone helps individuals achieve, sustain recovery of, and reclaim meaningful lives. Methadone is individually tailored, often requiring dose adjustments, and should never be shared with others.

Patients who take methadone at home must follow prescribed guidelines, as they are not under direct supervision like those in opioid treatment programs. Pregnant and breastfeeding women can safely use methadone, and treatment should include prenatal care to reduce complications. Maintenance treatment with methadone in pregnancy does not cause birth defects. It prevents withdrawal symptoms, helping pregnant women manage OUD while minimizing risks to both mother and baby. However, pregnant women who experience withdrawal are at risk of miscarriage or premature birth, due to its contractile effect on the uterus.

Neonatal Abstinence Syndrome (NAS), which are withdrawal symptoms in newborns, may occur in newborns exposed to methadone. Symptoms typically appear within 72 hours after birth but can take up to two weeks. It is important to consult a physician, as NAS is influenced by many factors.

Naltrexone

Naltrexone, is an FDA-approved medication for the treatment of both alcohol use disorder (AUD) and opioid use disorder (OUD). It is available in two formulations: a daily oral tablet and an extended-release injectable administered every four weeks by a licensed practitioner. The injectable form requires a Risk Evaluation and Mitigation Strategy (REMS) to ensure that the benefits outweigh potential risks.

Naltrexone is one component of a comprehensive treatment plan, which includes counseling and other behavioral health therapies to provide patients with a whole-person approach.

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However, naltrexone is not suitable for everyone. It is not recommended for individuals under 18 years of age or those with certain health conditions.

Acamprosate

Acamprosate is used to help individuals in recovery from alcohol use disorder (AUD) maintain abstinence. It does not prevent withdrawal symptoms but helps reduce the urge to drink. Acamprosate is usually started on the fifth day of abstinence, reaching full effectiveness within five to eight days. It is taken in tablet form three times a day.

Disulfiram

Disulfiram is a medication used to treat chronic alcoholism and is most effective in people who have stopped drinking or are in the initial stages of abstinence. Taken in tablet form once daily, it should never be taken while intoxicated and must be avoided for at least 12 hours after drinking alcohol. When alcohol is consumed, it causes unpleasant side effects such as nausea, headache, vomiting, chest pain, and difficulty breathing. These symptoms can begin as soon as ten minutes after alcohol intake, irrespective of the amount consumed.

Recovery Programs

Developing a work-life integration program with supportive measures can play a crucial role in fostering a caring and supportive workplace culture.[14] Many physicians tolerate burnout symptoms despite personal consequences, but chronic work-related stress can lead to reduced patient care quality and physician attrition.

Interestingly, the factors that enhance physician fulfillment differ from those that contribute to burnout. Addressing physician well-being requires tailored approaches based on career phase, specialty, and practice setting. Organizational leaders must prioritize physician wellness by implementing sustained support initiatives that foster a workplace culture where well-being is valued.

Professional Silence

Failing to report impaired colleagues can prolong their addiction and endanger patients' safety. A 2010 study published in the *Journal of the American Medical Association (JAMA)* surveyed 1,800 physicians and found that 17% had encountered an impaired or incompetent colleague due to alcohol, drugs, or mental illness in the past three years.[36] However, only 67% reported the issue, with even lower reporting rates among small-practice physicians (44%) compared to those in universities or medical schools (77%).[36]

Beletsky, et al. highlight that Physician Health Programs (PHPs) have traditionally been regarded as highly effective alternatives to abstinence-only treatments. These programs are believed to succeed because physicians and other licensed healthcare professionals are considered uniquely motivated and disciplined in their recovery.[37]

The success of PHPs is widely attributed to their intensive regimens, long-term monitoring, and the potential for severe professional consequences if participants fail to comply, coupled with high motivation among participants to continue practicing in their field.[37] However, researchers argue that no well-controlled studies have adequately compared PHP participants who did and did not receive opioid-agonist therapy, particularly in relation to their OUD severity and other individual factors.[37]

There are two opposing perspectives on the use of opioid agonist therapy for treating OUD and SUD in healthcare professionals. Those opposed to opioid-agonist therapy argue that the neurocognitive effects of these medications interfere with clinical practice, which is a significant concern given the high rates of medical errors and the need to minimize errors in healthcare settings.

However, the contention that calibrated opioid-agonist pharmacotherapy leads to substantial impairment in cognition, psychomotor tasks, and memory is far from settled science.[37,38] Studies indicate that individuals receiving opioid-agonist therapy perform comparably to those undergoing non-medication-based treatment for OUD.[37,38]

The Health Professional Recovery Program (HPRP) is a confidential, non-disciplinary initiative that assists licensed or registered healthcare professionals in recovering from substance use disorders, chemical dependency, or mental health conditions.

To contact Florida's PRN program, call the toll-free helpline 1-800-488-4767.

Similarly, the Physicians' Recovery Network (PRN), a service sponsored by the APMA, offers peer consultation to podiatric physicians and their families dealing with alcohol dependency, mental health struggles, or physical impairments. The PRN provides referrals to external support services and operates on a colleague-to-colleague model, encouraging self-recognition of the problem(s) followed by the pursuit of individual assistance available from trained professionals. The PRN helpline (800-488-4767) ensures strict confidentiality in all communications.

Healthcare professionals diagnosed with a substance use disorder should seek treatment programs tailored to their profession. These specialized centers address workplace-specific challenges and design treatment plans that promote abstinence and recovery. Table 3 outlines resources available to podiatric physicians, as recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The Florida's PRN[BI1] participant manual states: "It is believed that most professionals suffering from a substance use disorder (SUD) can maintain abstinence through formal addiction treatment, mutual-help groups, antagonist therapy (e.g., oral or injectable naltrexone), and individual recovery programs. However, it is recognized that some individuals may require alternative or ancillary methods.[39] In rare cases, a participant may be unable to maintain absti-

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nence despite undergoing comprehensive treatment and monitoring (American Society of Addiction Medicine with healthcare-specific groups, naltrexone, and monitoring).[39]

To address these cases, Florida's PRN permits the use of closely supervised partial agonist opioid therapy or agonist maintenance therapy (e.g., methadone).[39] Partial agonist therapy is the preferred initial treatment when considering a medication-assisted program for opioid addiction.[39] To ensure the safety of participants who continue practicing, PRN has established protocols for approving maintenance opioid therapy.

Research indicates that anesthesiologists, retail pharmacists, and other healthcare professionals with direct access to opioids have lower relapse rates upon returning to practice when monitored naltrexone therapy is implemented.[39] Participants identified as high-risk for relapses or opioid overdose are required to take extended-release injectable naltrexone for a minimum of two years, unless medically contra-indicated. In exceptional cases, oral naltrexone may be approved.[39]

Considerations for Malpractice Insurance

Those engaged in a medical profession are actively caring for the general population. Impairment on the job can significantly impact those in their care. The chances of malpractice due to incorrect diagnosis, incorrect prescription of medication, laboratory orders, and other actions all increase when a healthcare provider is suffering from substance use disorder.

To explore the implications for malpractice insurance, I consulted Dr. Cicchinelli, Medical Director of PICA-ProAssurance. I asked:

"Are there any special procedures or requirements for a podiatrist who has been deemed fit to re-enter the podiatry profession after successful recovery from SUD before obtaining malpractice insurance coverage?"

In an email response dated March 1, 2025, Dr. Cicchinelli outlined several factors that may be considered before approving coverage.[40]

a. Did the physician treat patients while under the influence?

b. Did the physician self-report their substance use, or was it reported by a third party?

c. What treatment programs have they completed?

d. What additional measures have they taken to maintain long-term sobriety?

e. Do they practice independently, or are they part of a group setting where other physicians can monitor their performance?

Conclusion

Lower extremity specialists, including podiatrists, recognize that substance use disorder presents unique challenges among healthcare professionals. Furthermore, podiatrists can appreciate that knowledge of medicine and familiarity with substances in the medical setting provide HCPs with a skill set that intuitively should steer them away from danger but may instead be exploitative.

Healthcare professionals diagnosed with SUD should seek treatment programs designed specifically for medical professionals. These specialized programs address workplace-related challenges and develop personalized treatment programs that promotes long-term abstinence. Detoxification is the first step, allowing individuals to manage withdrawal symptoms and transition safely to a drug-free state. **PM**

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Dr. Smith is in private practice in Ormond Beach, FL.

CME EXAMINATION

SEE ANSWER SHEET ON PAGE 113.

1) _____ treats chronic alcoholism and is most effective in individuals who have already stopped drinking alcohol or are in the initial stage of abstinence. Unpleasant side effects (e.g., nausea, headache, vomiting, chest pain, difficulty breathing) may occur within 10 minutes of consuming alcohol.

A) Naloxone
B) Acamprosate
C) Methadone
D) Disulfiram

2) Each year, approximately _____ medical professionals experience substance or alcohol use disorders.

A) 1,000,000
B) 100,000
C) 500
D) 500,000

3) Although emergency medicine physicians represent only 3% of all physicians, they account for _____ of those enrolled in physician health programs for substance use disorder management.

A) 25–100%
B) 1–5%
C) 56–77%
D) 7–18%

4) Among surgeons, alcohol abuse or dependence rates are highest in women, with _____ affected compared to 13.9% of male surgeons.

A) 100%
B) 5.5%
C) 25.6%
D) 15.6%

5) Substance abuse and dependency have been observed to affect even those who are seemingly risk-averse, including healthcare providers (HCPs), who reportedly misuse substances at lifetime rates of _____, similar to the general population.

A) 1% to 33%
B) 95% to 100%
C) 15% to 25%
D) 10% to 15%

Continued on page 112

Continuing Medical Education

CME EXAMINATION

(Continued from page 111)

6) Buprenorphine acts as a partial opioid agonist at the μ-receptor and an antagonist at the _____.

A) Gamma-receptor
B) κ-receptor
C) β-receptor α-receptor
D) β-receptor

7) Higher rates of SUD are found among HCPs working in _____.

A) Long-term facilities
B) Outpatient centers
C) Medical-surgical units
D) All of the above are correct

8) To contact Florida's PRN program, call the toll-free helpline _____.

A) 1-800-488-4767
B) 1-444-650-0568
C) 1-900-555-8999
D) 1-800-800-9999

9) PRN participants at high risk for relapses or opioid overdose must take extended-release injectable naltrexone for at least _____, unless medically contra-indicated.

A) Five (5) years
B) Ten (10) years
C) Two (2) years
D) 36-48 hours

10) _____ is individually tailored and prescribed, frequently adjusted, and must never be shared.

A) Naloxone
B) Morphine
C) Codeine
D) Methadone

SEE ANSWER SHEET ON PAGE 113.

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(3) All answers should be recorded on the answer form below. For each question, decide which choice is the best answer, and circle the letter representing your choice.

(4) Complete all other information on the front and back of this page.

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To receive your CME certificate, complete all information and fax 24 hours a day to 1631-532-1964. Your test will be dated upon receipt and a PDF of your certificate of completion will be sent to the Email address on file with us. Please allow 5 business days for the return of your certificate. This service is available for $2.95 per exam if you are currently enrolled in the 10-exam CME program, and can be charged to your Visa, MasterCard, or American Express.

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ENROLLMENT FORM & ANSWER SHEET *(continued)*

EXAM #7/25
Exploring Substance Use Disorder Among Podiatric Physicians
(Smith)

Circle:

1.	A	B	C	D	6.	A	B	C	D
2.	A	B	C	D	7.	A	B	C	D
3.	A	B	C	D	8.	A	B	C	D
4.	A	B	C	D	9.	A	B	C	D
5.	A	B	C	D	10.	A	B	C	D

Medical Education Lesson Evaluation

Strongly agree [5]	Agree [4]	Neutral [3]	Disagree [2]	Strongly disagree [1]

1) This CME lesson was helpful to my practice ____

2) The educational objectives were accomplished ____

3) I will apply the knowledge I learned from this lesson ____

4) I will makes changes in my practice behavior based on this lesson ____

5) This lesson presented quality information with adequate current references ____

6) What overall grade would you assign this lesson?

A B C D

7) This activity was balanced and free of commercial bias.

Yes _____ No _____

8) What overall grade would you assign to the overall management of this activity?

A B C D

This CME has been certified by a psychometrician as taking a minimum of 1.5 hours to complete.

What topics would you like to see in future CME lessons? Please list :

_____

_____

_____

_____

_____

_____