**Patient Electronic Directly Observed Therapy (e-DOT) Agreement Form**

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

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, understand I have been diagnosed with tuberculosis (TB) and need to take medication to treat it.

If I do not take the medication I might:

* Be sick longer.
* Spread TB to others.
* Develop drug-resistant TB.
* Die from TB.

I will film or record myself swallowing the pills needed to treat me for TB on a smartphone or computer. This is called electronic directly observed therapy (e-DOT).

e-DOT is scheduled for:

Days of week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If I am unable to keep an appointment, I will call the health department as soon as possible.

I understand the phone or camera given me is property of the Health Department. I agree to return the phone or camera to the Health Department at the end of my treatment or upon request. I agree to allow Health Department staff watch me take my pills by e-DOT. I understand that I may switch to in-person DOT at any time during my treatment.

I have read this agreement and understand the following (initial each box):

Taking TB medication is very important.

I am responsible for the tasks mentioned above.

If I fail to complete these tasks, legal action may be taken to make sure I finish treatment.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Health Department

Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_