

# IOWA PHARMACY RECOVERY NETWORK, INC. PRELIMINARY CONTRACT FOR STUDENT

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

**CLIENT NAME** \_\_\_\_\_

School Address \_\_\_\_\_  
\_\_\_\_\_

School Phone (\_\_\_\_) \_\_\_\_\_

Home/Permanent Address \_\_\_\_\_  
\_\_\_\_\_

Home/Permanent Phone (\_\_\_\_) \_\_\_\_\_

Work Address (if applicable) \_\_\_\_\_  
\_\_\_\_\_

Work Phone (if applicable) (\_\_\_\_) \_\_\_\_\_

Preferred E-Mail \_\_\_\_\_  
\_\_\_\_\_

**ADVOCATE NAME** \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

E-Mail \_\_\_\_\_  
\_\_\_\_\_

**TREATMENT CENTER** \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

E-Mail \_\_\_\_\_  
\_\_\_\_\_

Initials: (Client/Advocate)

\_\_\_\_/\_\_\_\_

1. I am voluntarily entering into this contract solely for the purpose of assuring a mutual understanding that I will complete an evaluation at the above stated treatment center on (date) \_\_\_\_\_.

\_\_\_\_/\_\_\_\_

2. I fully understand this preliminary contract is designed to allow the College of Pharmacy to assist me, on both a personal and professional level, in determining my ability to attend pharmacy school and/or work as a pharmacist intern.

\_\_\_\_/\_\_\_\_

3. I understand that since I have not diverted controlled substances for purposes other than personal use, my progress will be kept confidential with the College of Pharmacy until it is determined whether or not it is recommended for me to receive further treatment.

\_\_\_\_/\_\_\_\_ 4. I understand if I do not complete an evaluation on the above stated date or if I otherwise fail to cooperate or comply with the program, or if it is determined that I am impaired and such impairment is not substantially alleviated through intervention and treatment as determined by the College of Pharmacy in consultation with treatment providers, or if otherwise required by law, the College of Pharmacy may disclose all evidence of impairment to the full board.

\_\_\_\_/\_\_\_\_ 5. I agree, that if the outcome of my evaluation shows that my ability to attend pharmacy school or work as a pharmacist intern is compromised by my use of chemical substances or my mental or physical health, I will enter into a formal contract agreement with the Iowa Pharmacy Recovery Network, Inc. (IPRN).

\_\_\_\_/\_\_\_\_ 6. I understand that if (1) I refuse to cooperate with the program or otherwise comply with the requirements of this contract, or (2) refuse to submit to treatment, or (3) my impairment is not substantially alleviated through intervention and treatment as determined by the College of Pharmacy and IPRN, or (4) if it is determined that due to such impairment, I am in eminent danger to myself or the public, or (5) information comes to the attention of the IPRN regarding the undersigned's activities which discloses no illegal distribution of controlled substances or legend drugs to other individuals, or (6) if otherwise required by law, my situation and all information concerning the same may be reported to the full board.

\_\_\_\_/\_\_\_\_ 7. I agree to the following special terms as they apply to my individual situation (including any practice restrictions): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name of Pharmacy Student  
(*please print*)

\_\_\_\_\_  
Signature of Pharmacy Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of College of Pharmacy Faculty/IPRN Volunteer

\_\_\_\_\_  
Date