

IOWA PHARMACY RECOVERY NETWORK, INC. PRELIMINARY CONTRACT

Date: _____

Client's Initials: _____

CLIENT NAME _____

Home Address _____

Home Phone (____) _____

Work Address _____

Work Phone (____) _____

Preferred E-Mail _____

ADVOCATE NAME _____

Phone (____) _____

E-Mail _____

TREATMENT CENTER _____

Contact _____

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 IPRN to assist me, on both a personal and professional level, in determining my ability to practice pharmacy as a pharmacist or pharmacy technician or to attend pharmacy school.

____/____ 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 Iowa Pharmacy Recovery Network, Inc. and the board's secretary/director or their designee.

____/____ 4. I understand, in order to protect myself until a formal contract is signed with IPRN or until my case is dismissed, this preliminary contract will be forwarded to a designee of the Iowa Board of Pharmacy Examiners (hereafter referred to as the "board"). Furthermore, I understand this information will be kept in a confidential file and board staff and member access to such

confidential information shall be limited to essential named personnel. I am aware that although material in board investigative files is confidential, information in those files may be incorporated into a public document in the event that the board files a statement of charges. (Exception for students.)

____/____ 5. 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 IPRN in consultation with treatment providers, or if otherwise required by law, the IPRN may disclose all evidence of impairment to the full board.

____/____ 6. I agree, that if the outcome of my evaluation shows that my ability to practice pharmacy or attend pharmacy school 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).

____/____ 7. 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 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.

____/____ 8. I agree to the following special terms as they apply to my individual situation (including any practice restrictions): _____

Name of Pharmacist, Pharmacy Technician, Pharmacy Student
(please print)

Signature of Pharmacist, Pharmacy Technician

Date

Signature of IPRN Advocate

Date