

IOWA PHARMACY RECOVERY NETWORK, INC. CLIENT RECOVERY CONTRACT FOR STUDENTS

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 _____

PHYSICIAN _____

Address _____

Phone (____) _____

E-Mail _____

All provisions included in this contract which are initialed specifically apply to my situation and contract with the Iowa Pharmacy Recovery Network, Inc.

(items require a signature)*

Initials: (Client/Monitor)

____/____

1. *I fully understand this Contract is designed to allow the IPRN to assist me, on both a personal and professional level, as a recovering impaired pharmacy student and is entered solely for the purpose of assuring a mutual understanding of the terms and times specified for my participation in the IPRN program designated for my rehabilitation and recovery by the IPRN.

____/____ 2. *I understand this contract may be incorporated into an order of the Iowa Board of Pharmacy Examiners (hereafter referred to as the "board") as a result of an independent complaint or report about my impairment and subsequent investigation by the board. In such an event, I understand the board may require changes in the terms of this contract and may participate in the program designated by the committee without my prior consent.

____/____ 3. *I agree to notify my advocate prior to taking prescription medications, non-prescription medications (OTCs), herbs and other dietary supplements, and/or alcohol containing products which are prescribed for me as a legitimate part of my medical care. Furthermore, I understand that I am responsible for all drugs that I take and that having a prescription does not relieve me of that responsibility.

____/____ 4. *I understand that documentation of my progress will be kept confidential at the IPRN headquarters. I agree to the terms of this contract for a period no less than five (5) years from the date of my signature or until my termination from the IPRN program.

____/____ 5. *I agree to send a quarterly report (details included in this contract) to IPRN at 8515 Douglas Avenue, Suite 16, Des Moines, Iowa 50322, jmoulton@iarx.org. Reports are due to IPRN by March 15, June 15, September 15, December 15. Failure to submit these reports in a timely manner will be documented in IPRN's quarterly report provided to the Executive Director/Secretary of the Iowa Board of Pharmacy Examiners.

____/____ 6. *I understand that all expenses incurred as a result of my impairment and recovery shall be my responsibility. I further agree to pay all costs for chemical screen monitoring (if necessary) for my own protection and to document my recovery. I understand failure to pay for any portion of my recovery expenses within ten days of billing (unless other arrangements have been approved in advance) is a breach of the terms of this contract and may result in the IPRN filing a report to the board.

____/____ 7. I agree to the following terms concerning my treatment:
(indicate provisions that apply):

____/____ To enter _____ hospital or treatment center for detoxification on ____/____/____(d/m/y) and shall remain until discharged by my physician/counselor.

____/____ To enter _____ hospital or treatment center for inpatient treatment on ____/____/____(d/m/y) and shall remain until discharged by my physician/counselor.

____/____ To enter _____ outpatient treatment program for _____ weeks.

____/____ 8. I agree to the following terms upon completion of my inpatient or outpatient treatment:

(indicate provisions that apply):

____/____ To attend and participate in aftercare support group counseling in _____ (city), _____ times per month/week (*circle one*) for the period of the duration of this contract and to submit monthly reports to my monitor with a list of meetings attended which has been signed or initialed by the secretary of the group.

Clients may be excused only with prior notification of their IPRN advocate, and may miss a maximum of 10% of the required peer group counseling meetings per year (____ meetings).

____/____ To attend AA, CA or NA (*circle all that apply*) meetings as specified below for the period of the duration of this contract and to submit reports to my advocate with a list of meetings attended which has been initialed by a regular attending member of the group. _____

If the client is not comfortable with AA, NA or CA meetings, a written alternative and demonstrated success may be submitted for consideration.

____/____ 9. I agree to the following special terms as they apply to my individual situation (including any practice restrictions): _____

____/____ 10. I agree to provide urine/serum samples for chemical screen monitoring at the discretion of the IPRN and my advocate. These tests will be random and unannounced. I agree to follow the instructions attached regarding laboratory procedures.

____/____ 11. *I agree to notify the committee of any instance of noncompliance with the terms of this contract, including, but not limited to, a recurrence or worsening of my condition. My IPRN advocate shall then submit a report to the IPRN committee and to the board's secretary/director or their designee, this contract will become null and void, and I will enter into a new contract. I further understand that my failure to report any instance of noncompliance or upon my second noncompliance occurrence, my contract will be terminated and my case will be automatically referred to the full board.

____/____ 12. I shall fully and openly discuss my illness and treatment with my spouse/significant other, and encourage him/her to accompany me to open NA/AA meetings and to attend Al-Anon meetings or similar support groups for mental health or substance impairment that assist family members.

____/____ 13. *I agree to identify a single primary physician and his/her referents exclusively for all of my medical needs for the duration of this contract further authorize this physician to share with IPRN information on any medication prescribed for me and other information that may be pertinent to my recovery.

Dr. _____
Practice _____
Phone _____

____/____ 14. I agree to identify a work site monitor to regularly observe and/or supervise me throughout my recovery. I understand that my work site monitor will report quarterly to my IPRN advocate, and more frequently if necessary, regarding my recovery progress.

Name _____
Pharmacy _____

____/____ 15. *I hereby authorize the IPRN to transfer information concerning me from IPRN to the person(s) treating me for the condition that resulted in this contract. Further, I hereby authorize full disclosure to the IPRN of information from said person(s) concerning my participation in treatment, my progress, prognosis, ability to return to or remain in active practice and otherwise comply with the terms of this contract.

____/____ 16. *I agree to notify my IPRN advocate one week in advance of any changes in address, telephone number(s), employment, legal status, and marital or family conditions that might in any way have an impact on my recovery.

____/____ 17. *I agree to notify my IPRN advocate one week in advance of residing at a different location than my home address listed on this contract for longer than two weeks. (i.e. vacation, internship, etc.)

____/____ 18. *I will immediately notify IPRN if I leave the state of Iowa to live, practice pharmacy, or continue my schooling. The notification shall include the date of departure, new address and phone number. I understand the period of time I do not reside in Iowa will not count towards fulfilling this agreement with the IPRN, unless I enroll in a program approved by the IPRN in the state in which I reside. I give permission to the IPRN to communicate with the representatives of that state's recovery assistance program.

____/____ 19. *I understand that if there is a concern of any psychiatric difficulties during the period of this contract, I agree to reevaluation by mental health provider for a thorough examination and recommendation for therapy.

____/____ 20. I understand that since I have not diverted controlled substances or legend drugs for purposes other than personal use, documentation of my progress will be kept confidential with the Iowa Pharmacy Recovery Network and the board's secretary/director or their designee.

____/____ 21. *In the event that IPRN refers my case to the board, I understand that the contract and all documents related to my impairment and recovery, including all documents from evaluating facilities and treatment providers, shall be provided to the board to be maintained as part of a confidential investigative file. I am aware that although material in board investigative files is confidential, information from those files may be incorporated into a public document in the event that the board files a statement of charges.

____/____ 22. *I understand that if I experience a recurrence or worsening of my condition at anytime after I have been released from this contract, IPRN may refer the contract and all documents related to my impairment and recovery, including all documents from evaluating facilities and treatment providers, to the board to be maintained as part of a confidential investigative file. I am aware that although material in the investigative file is confidential, information from those files may be incorporated into a public document in the event that the board files a statement of charges.

____/____ 23. *As a student, I understand that the contract and all documents related to my impairment and recovery, including all documents from evaluating and treatment providers, shall be provided to the board and to the college of pharmacy liaison to be maintained as part of a confidential investigative file. I am aware that although material in board and college investigative files is confidential, information from these files may be incorporated into a public or disciplinary document in the event that the board or college files a statement of charges.

____/____ 24. *I understand that my participation in this program does not relieve the board of any duties and does not divest the board of any authority or jurisdiction otherwise provided by law. I understand that the board is not precluded from investigating and taking disciplinary action against me for any violations of the statutes or rules governing the practice of pharmacy which occur during my participation in this program.

____/____ 25. *I agree to release and hold harmless the IPRN, the Iowa Pharmacy Association and its respective members, officers, employees and agents who perform services under this agreement and acknowledge that such persons or entities who in good faith, for the purpose of aiding me with respect to my condition, shall be immune from any civil liability.

____/____ 26. *As a student, I understand that if I experience a recurrence or worsening of my condition at anytime after I have been released from this contract, IPRN may refer the contract and all documents related to my impairment and recovery, including all documents from evaluating facilities and treatment providers, to the board and the college of pharmacy liaison to be maintained as part of a confidential investigative file. I am aware that although material in board and college investigative files is confidential, information from those files may be incorporated into a public or disciplinary document in the event that the board or college files a statement of charges.

____/____ 27. *I understand that the use of the term “contract” in this document includes the terms of this client recovery contract and any addenda hereto.

____/____ 28. *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 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.

____/____ 29. *I hereby certify that I have read this contract, have had an opportunity to ask questions and understand its terms. This contract cannot be changed unless approved by all parties.

____/____ 30. *As a student, I understand that my participation in this program does not relieve the board or the college of pharmacy of any duties and does not divest the board or college of pharmacy of any authority or jurisdiction otherwise provided by law or college policy. I understand that the board and the college of pharmacy are not precluded from investigating and taking disciplinary action against me for any violations of the statutes or rules governing the practice of pharmacy, or policies of the college of pharmacy, which occur during my participation in this program.

Name of IPRN Client (*please print*)

Signature of IPRN Client

Date

Signature of IPRN Advocate