

**IOWA PHARMACY RECOVERY NETWORK, INC.  
CLIENT RECOVERY CONTRACT**

<b>Date:</b>
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<b>CLIENT NAME:</b>	
Home Address:	
Home Phone: (____)	Cell Phone: (____)
Preferred E-Mail:	
<b>EMPLOYMENT:</b>	
Pharmacy Address:	
Pharmacy Phone: (____)	
Pharmacy Contact:	
<b>TREATMENT CENTER:</b>	
Address:	
Phone: (____)	
Treatment Contact:	
<b>PHYSICIAN:</b>	
Address:	
Phone: (____)	
<b>ADVOCATE:</b>	
Phone: (____)	

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

**Initials: (Client/Advocate)**

\_\_\_\_/\_\_\_\_ 1. I fully understand this Contract is designed to allow IPRN to assist me, on both a personal and professional level, as a recovering impaired pharmacist or recovering impaired pharmacy technician and is entered solely for the purpose of assuring a mutual understanding of the terms, conditions, stipulations and times specified for my participation in the IPRN program.

\_\_\_\_/\_\_\_\_ 2. I understand that the use of the term "contract" in this document includes the terms, conditions, stipulations and times of this client recovery contract and any addenda hereto.

\_\_\_\_/\_\_\_\_ 3. I understand this contract may be or may have been 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 this event, I understand the board may require changes in the terms of this contract without my prior consent.

\_\_\_\_/\_\_\_\_ 4. I understand that since I have not diverted controlled substances 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.

\_\_\_\_/\_\_\_\_ 5. 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 completion or termination from the IPRN program.

\_\_\_\_/\_\_\_\_ 6. I agree to send a monthly report (detailing compliance with this contract) to IPRN, 31702 Granite Avenue, Hinton, Iowa 51024, 1-890-877-4776, or to emily@proheights.com. Failure to submit these reports in a timely manner will be documented in IPRN's monthly confidential report to be provided to the board. I agree to send IPRN copies of all of my reports 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. Following treatment I agree 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 include in my monthly report a list of meetings attended which has been signed or initialed.

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

\_\_\_\_/\_\_\_\_ 9. I agree to attend AA, NA, CA, or \_\_\_\_\_ (*circle all that apply*) meetings \_\_\_\_\_ times per month/week (*circle one*) for the period of the duration of this contract and to include in my monthly report a list of meetings attended which has been signed/initialed by a regular attending member of the group.

*(If the client is not comfortable with AA, NA, CA, or other 12 step program meetings, a written alternative with demonstrated success may be submitted for consideration.)*

\_\_\_\_/\_\_\_\_ 10. 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.

\_\_\_\_/\_\_\_\_ 11. I understand that all expenses incurred as a result of my impairment and recovery shall be my responsibility. I further to pay all costs for chemical screen monitoring 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 this contract.

\_\_\_\_/\_\_\_\_ 12. I agree to provide urine/serum samples, hair or buccal samples for chemical screen monitoring at the discretion of IPRN and/or my advocate. These tests will be random and unannounced. I agree to follow the instructions regarding laboratory procedures.

\_\_\_\_/\_\_\_\_ 13. I agree to notify my monitor 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 having a prescription does not relieve me of that responsibility.

\_\_\_\_/\_\_\_\_ 14. I agree to notify my monitor 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 monitor 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 non-compliance occurrence, my contract will be terminated and my case will be automatically referred to the full board.

\_\_\_\_/\_\_\_\_ 15. 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.

\_\_\_\_/\_\_\_\_ 16. 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. I 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. \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_

\_\_\_\_/\_\_\_\_ 17. 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, and prognosis, ability to return to or remain in active practice and otherwise comply with the terms of this contract.

\_\_\_\_/\_\_\_\_ 18. 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.

\_\_\_\_/\_\_\_\_ 19. I agree to identify a work contact:

Name \_\_\_\_\_  
Pharmacy \_\_\_\_\_

I understand that my work contact may call my IPRN monitor if there are issues that he/she feels IPRN should know. I understand that my IPRN advocate may contact this person for information on my recovery.

\_\_\_\_/\_\_\_\_ 20. 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.

\_\_\_\_/\_\_\_\_ 21. 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.)

\_\_\_\_/\_\_\_\_ 22. I will immediately notify my IPRN advocate 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.

- \_\_\_\_/\_\_\_\_ 23. I understand that I will not use alcohol, mood-altering or illegal drugs for the duration of this contract. I will notify my monitor of any OTC medications, herbs or other medication that I am taking. I further agree to follow all federal and state laws and to notify my monitor if I experience any legal difficulty including but not limited to questioning, giving testimony, arrest or conviction of a crime and/or civil issues such as bankruptcy or lawsuit which may interfere with my recovery.
- \_\_\_\_/\_\_\_\_ 24. I agree to release and hold harmless the IPRN, the Iowa Board of Pharmacy Examiners, 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 act in good faith, for the purpose of aiding me with respect to my condition, shall be immune from any civil liability.
- \_\_\_\_/\_\_\_\_ 25. I agree to release and hold harmless anyone who contracts with IPRN to perform services under this agreement and acknowledge that such persons or entities who act in good faith, for the purpose of aiding me with respect to my condition, shall be immune from any civil liability.
- \_\_\_\_/\_\_\_\_ 26. 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.
- \_\_\_\_/\_\_\_\_ 27. 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.
- \_\_\_\_/\_\_\_\_ 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 agree to the following special terms as they apply to my individual situation (including any practice restrictions):

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\_\_\_\_/\_\_\_\_ 30. 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.

**Name of IPRN Client (*please print*)**

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**Signature of IPRN Client**

\_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of IPRN Advocate**

\_\_\_\_\_ **Date** \_\_\_\_\_

**Iowa Pharmacy Recovery Network  
31702 Granite Avenue  
Hinton, IA 51024**

**emily@proheights.com  
1-877-890-4776**