

TENNESSEE PHARMACISTS RECOVERY NETWORK

EXTENDED AFTERCARE CONTRACT

The Tennessee Pharmacists Recovery Network (TPRN), by and through its duly authorized representative, agrees to assume an advocacy role on behalf of and for the benefit of _____, before the professional licensure board and/or any other appropriate agency or entity as may be required, provided the above referenced recovering pharmacist agrees to diligently and absolutely abide by the terms and conditions of this contract. I understand this contract cannot be entered into until successful completion of an initial treatment program specifically designed for healthcare professionals at a TPRN approved site consisting of inpatient detoxification and at least 90 days in a half-way (residential) house program. I am aware this contract is designed to meet the needs of the individual.

1. I agree to the terms of this contract for a period of the greater of sixty months from the date of this contract or the end date specified in any Board of Pharmacy Consent Order to which I agree.
2. I am responsible for all expenses connected with my treatment including costs incurred as a result of this extended aftercare phase.
3. I am responsible for timely reporting of all aspects of my recovery to my designated advocate including, but not limited to:
 - urine screens scheduled through the random screen check in process must be performed on date selected, or the following day if I am unable to test on date selected and next day testing is approved in advance by TPRN representative.
 - urine screens must be performed within 24 hours of direct notification and request from a representative of the TPRN program.
 - report to re-evaluation directive must be initiated on-site within forty-eight hours - discharge summary due to advocate within seven days of discharge.
 - meeting records report must be presented to advocate by the tenth of the following month.
4. I agree to follow any recommendations imposed by the Board of Pharmacy.
5. My primary physician is:
Name: _____
Address: _____
Telephone: _____
6. I agree to offer and obtain, at my own expense, supervised urine/blood/hair samples for drug screens randomly and/or at the discretion of the TPRN and/or my primary physician. Further, I agree that a report from my physician or other health care provider of requested screens performed and any other information will be provided to my advocate.

7. I agree to properly complete and sign the Chain of Custody Forms submitted at the time of my drug screens. Failure to properly complete the form will result in my having to submit to a repeat test.
8. I agree to the following advocate who will assume supervisory responsibility for my extended aftercare program: _____
9. I agree to work no more than 40 hours in any seven day period unless approved in advance by TPRN. Further work restrictions apply as follows: _____

10. I agree to abstain from consuming foods that are prepared or flavored with alcohol or using products containing alcohol including, but not limited to, mouthwash, hand sanitizer, breath spray, and over the counter or prescription medications which contain alcohol except with the prior approval of the TPRN.
11. I agree to abstain completely from any mood-altering chemicals except as prescribed by my primary physician with the consultation and approval of the TPRN. I will provide in a timely manner to my advocate, copies of all prescriptions prescribed for me. Further, I agree to discard any unused portions of medications remaining after a reasonable course of therapy which were legitimately prescribed for me.
12. In the event of relapse, I agree to notify the TPRN and abide by their recommendations for reassessment and/or further treatment.
13. I understand the TPRN encourages me to become a member of my local and state professional organizations.
14. At minimum, I will attend during the term of this contract, a 12-step self-help group (AA, SLAA, GA, CA, NA, OA, etc.) at a frequency of at least three times per week and any other meetings required as described below. I will attend the TPRN group meeting in my area unless excused in advance by my advocate. I agree to keep a log of meetings I attend and will make this log available monthly to my advocate. The log will contain date, time, and location of meeting, and signature of the chairperson of the meeting.

DAY	TIME	NAME OF GROUP	LOCATION

15. I agree to attend one meeting per day in the first 90 days after discharge from a TPRN approved treatment center. Any exception must be approved in advance from TPRN.

16. I agree to the following special terms concerning my disease:

17. I understand that the TPRN Committee will re-evaluate the recovering pharmacist's recovery process every two years or as needed. I understand that TPRN reserves the right to alter/modify any and all parameters of this contract based on this review.

18. I agree and understand, in order to foster a more candid and open working relationship between the parties, that all communication by and between the recovering pharmacist and his/her TPRN representative concerning and regarding the recovering pharmacist's current or past physical or mental condition, or any other matter, fact or bit of information pertinent to any ongoing, pending or future obligation before the professional licensure board or any other appropriate agency is and shall be considered privileged and confidential information. Accordingly, disclosure to any third party other than to the professional licensure board, the TPRN Committee as a whole, or any other appropriate agency by the TPRN or its representative is prohibited except with my written consent as the recovering pharmacist. This privilege of confidentiality shall include but not be limited to any and all written correspondence, urine or blood test reports, medical reports, telephone conversations, all notes and work product of the TPRN representative.

19. I understand that if I do not adhere to conditions of this contract my advocate with the support of the TPRN Committee may elect to relinquish advocacy and may so notify appropriate agencies and/or persons before which he/she has acted or may have an opportunity to act on my behalf.

Signatures of Acceptance:

Recovering Pharmacist: _____

Address: _____

Phone Number: _____

Representative of Tennessee Pharmacists Recovery Network:

Date: _____