Extended Aftercare Contract - Pharmacist

The Tennessee Pharmacy 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 assessment and treatment program specifically designed for healthcare professionals at a TPRN approved site consisting of inpatient detoxification if needed and at least 90 days total in treatment including time 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 or other 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 Program representative.

   - all 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

   - meeting records must be documented via the Affinity/Spectrum Compliance Application.

4. I agree to follow any recommendations imposed by the Board of Pharmacy.

5. I agree to see my primary physician at least annually and provide TPRN with documentation of that visit. I also agree to provide notification to my primary physician and the TPRN Program of being seen by any other medical provider including a walk-in clinic or emergency room.

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, excessive use of hand sanitizer, breath spray, and over the counter or prescription medications which contain alcohol except with the prior approval of the TPRN.

11. I understand I can consume medications on the TPRN Program list of approved over-the-counter medications on a short-term basis not to exceed 7 days and that I must report use of those medications to my advocate as soon as is possible. I agree to abstain from consuming any cannabidiol containing product except as prescribed by my primary care physician. I agree to abstain from consuming any over-the-counter medications on a routine basis except as prescribed by my primary care physician or approved in advance by my TPRN advocate or the TPRN Program Director.

12. 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, except in the case of an emergency or upon a proper referral. I will provide, in a timely manner, to the TPRN Program Director or my advocate copies of all prescriptions prescribed for me. Further, I agree to discard any unused portions of medications remaining after the limited reasonable course of therapy

which were legitimately prescribed for me. I will discard the unused remainder of all controlled substances prescriptions prescribed for me within 30 days of obtaining the prescription unless expressly written for a specific greater days supply.

13. In the event of relapse, I agree to notify the TPRN and abide by their recommendations for reassessment and/or further treatment.

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. Unless I am on an out-of-town trip previously approved, if I will miss the TPRN group meeting on a given day, I will check in with my advocate on the day of that meeting. I agree to keep a log of meetings that I attend via the Affinity/Spectrum Compliance App and will make this log available to my advocate upon request. The log will contain date, time, type of meeting, and location of meeting which will be captured via the geo location feature provided by the App.

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. If recommended at any time as part of my specific recovery program, I agree to obtain a psychiatrist for ongoing medication supervision and monitoring. I understand the need for and will request that my psychiatrist provide free and unlimited release of all information concerning my health and participation in treatment to the TPRN. I agree to have my psychiatrist send quarterly updates to the TPRN regarding my mental status and progress and to notify the TPRN immediately for discontinuation of therapy.

    My psychiatrist will be: ____

    Phone: ______________________Address: ________________________________

    City: ________________________ State: ____________ Zip: ____________

19. If recommended at any time as part of my specific recovery program, I agree to obtain a therapist to continue to explore emotional, spiritual, and/or relational issues. I understand the need for and will request that my therapist provide free and unlimited release of all information concerning my health and participation in treatment to the TPRN. I agree to have my therapist send quarterly updates to the TPRN regarding my mental status and progress and to notify the TPRN immediately for discontinuation of therapy.

    My therapist will be: ____

    Phone: _____________________Address: ______________________________

    City: _______________________ State: ____________ Zip: ____________

20. 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.

21. I understand and agree to treat all information shared at any meeting or event occurring as part of the TPRN Program including any information shared regarding any participant in the TPRN program as privileged and strictly confidential. I understand I am not permitted to disclose any of that information with any third party at any time without the written permission of the TPRN Program Director regarding the TPRN Program or its participants and, regarding information about an individual participant, the written permission of the TPRN Program Participant regarding that participant.

22. 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.

23. I agree to update my personal contact and employment information with the TPRN Program Director any time there is a change.

In consideration of the services and assistance provided by the TPRN and for allowing me to participate in the TPRN's program, I agree as follows:

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend and indemnify TPRN and its representatives, agents, attorneys, officers and employees from any and all claims, suits or causes of action by me, my heirs or my personal representatives that may arise (in any way, form or fashion) out of: my participation in TPRN programs and services; the decisions of the TPRN; the TPRN's furnishing information, data, reports or records to any entity in performance of the TPRN's duties; or for damages resulting from any decisions, opinions, actions and proceedings rendered, entered or acted upon by the TPRN.

I specifically understand that I am releasing, discharging, and waiving my claims of action that I may have presently or in the future for the negligent acts or other conduct by the TPRN and its representatives, agents, officers, attorneys, or employees.

I HAVE READ THE ABOVE WAIVER OF RELEASE AND BY SIGNING IT AGREE IT IS MY INTENTION TO RELEASE ANY AND ALL CLAIMS I MAY HAVE AGAINST THE TPRN FOR ITS WORK AND SERVICES IT PROVIDES IN THE COURSE OF MY RELATIONSHIP WITH THE TPRN.

________ (Initials)

Signatures of Acceptance

Recovering Pharmacist:

____

Address:

____

Phone Number:

____

Email:

____

Representative of Tennessee Pharmacists Recovery Network:

____

Date:

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