

## Iowa Monitoring Program for Pharmacy Professionals (IMP3)

### Self-Report Form

Name: \_\_\_\_\_ Date of Report: \_\_\_\_\_

Home Address: \_\_\_\_\_

Work Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email address (where confidential messages may be sent): \_\_\_\_\_

Iowa License/Registration Number: \_\_\_\_\_

Please describe reasons for this self-report (use additional sheets if necessary):

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Have you undergone an evaluation for this condition?  Yes  No

Where: \_\_\_\_\_

Have you received any treatment for this condition?  Yes  No

Where: \_\_\_\_\_

Who was your treating physician: \_\_\_\_\_

Where did this treatment take place: \_\_\_\_\_

What were the dates of treatment: \_\_\_\_\_

Pharmacy professionals or applicants may be ineligible to participate in the IMP3 for the following reasons:

- **The applicant or pharmacy professional engaged in the unlawful diversion or distribution of controlled or illegal substances for personal gain or profit.**
- **The applicant or pharmacy professional is currently under a Board of Pharmacy order for alcohol or drug abuse or for another issue related to an impairment.**
- **The applicant or pharmacy professional has caused harm or injury to a patient.**
- **The Board of Pharmacy is currently investigating the applicant or pharmacy professional for matters related to an impairment.**
- **The applicant or pharmacy professional provided inaccurate, misleading, or fraudulent information or failed to cooperate with the Board of Pharmacy or IMP3.**

**Do any items in the above list apply to you?** *(Please note, if it is determined at some point in the future that you were ineligible for IMP3 participation due to one of the above criteria, you may be referred to the Iowa Board of Pharmacy.)*

Yes\* (if yes, please explain)

No

*All information in possession of IMP3 and its personnel regarding pharmacy professionals is **confidential**. Do you give the IMP3 permission to inquire about the material facts you have provided in this self-report?*

Yes

No

Pharmacy Professional Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Please return this form to:**

**IMP3**

**400 SW 8<sup>th</sup>, Suite C**

**Des Moines, Iowa 50309-4686**

**If you have any questions or comments, call (515) 281-6006. Fax 515-242-0155**

\*Please note that an electronic signature is considered to be a legal substitute for your hand written signature.