IOWA MONITORING PROGRAM
for Pharmacy Professionals

Quarterly Report – Participant

Participant Name:
Contact Information: **(Include mailing address, phone #, and email address)**

Reporting Quarter:	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	January-March	April-June	July-September	October-December
	Report due April 20th	Report due July 20th	Report due Oct 20th	Report due Jan 20th

Dates of sessions with ALL providers:		
Current symptoms and treatment:		
Have your symptoms improved and/or declined? Please explain.	**YES**	**NO**
Has there been a change in diagnosis and/or treatment? Please explain.	**YES**	**NO**
Has there been a change in your support system? Please explain and list current support system.	**YES**	**NO**
Describe any challenges and/or successes within your family.		

Describe any challenges and/or successes with your peers.		
Describe any challenges and/or successes with your co-workers.		
Have you changed employment or do you anticipate any changes next quarter? Please explain.	**YES**	**NO**
Do you have any travel plans? If yes, please explain.	**YES**	**NO**
Do you have any requests for IMP3 to consider? If yes, please explain.	**YES**	**NO**
Are you in compliance with your IMP3 contract? If no, please explain.	**YES**	**NO**
Would you like the IMP3 case manager to contact you?	**YES**	**NO**
Comments, Questions, or Concerns:		
SIGNATURE	**DATE**	

Complete this form and return to IMP3 either by email, mail, or fax.

Email: Rebecca.Carlson@iowa.gov

Fax (515) 725-0642

Mail to: Board of Pharmacy, Attn: IMP3

400 SW 8th Street, Suite E

Des Moines, IA 50309