IOWA MONITORING PROGRAM
for Pharmacy Professionals

Quarterly Report – Worksite Monitor

Participant Name:	**Worksite Monitor Name and Credentials:**
	Contact Information:

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

How often do you meet with the participant?	**Daily**	**Weekly**	**Monthly**	**Quarterly**
Dates of meetings:				

Are you aware of any changes in the following? If yes, please explain.		
Attendance	**YES**	**NO**
Personal habits or general appearance	**YES**	**NO**
Practice performance	**YES**	**NO**
Interpersonal relationships	**YES**	**NO**
Social behavior	**YES**	**NO**
Use of prescription/non-prescription drugs and/or alcohol	**YES**	**NO**
Are you aware of any challenges the participant faced this quarter? Please explain.	**YES**	**NO**
Are you aware of any successes the participant had this quarter? Please explain.	**YES**	**NO**
Do you have any concerns about the participant? 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