



IOWA PROFESSIONAL HEALTH PROGRAMS Quarterly Report - Interstate Monitoring

Your Name:

Indicate which quarter this report covers:

1st Quarter

2nd Quarter

3rd Quarter

4th Quarter

List current requirements with primary monitoring contract (i.e. therapy, group, meetings, drug screens):

Current Symptoms & Treatment Goals:

What, if any, barriers have you met in working toward your goals?

What is your current support system?

Describe any challenges and successes in your personal life:

Describe any challenges and success with your employment, co-workers, hours, etc.:

Has there been a change in your work status such as on call, hours, loss of staff, increase in duties, change in duties, etc.?

How many days a month do you currently practice in Iowa?

Do you have plans to move your primary practice or residence to Iowa? If yes, please explain.

Yes

No

Are you able to maintain your mental health, sobriety, etc. in the face of family/personal life & work demands?	
If applicable, how many self-help meetings are you attending each week?	
If applicable, how often do you meet with your sponsor?	
Are you in compliance with the terms of your contract/ agreement with the health program that serves as your primary monitor? If no, please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any requests for the IPHP staff or committee to consider?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like the IPHP staff to contact you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Your Signature:	Date:

PROGRAM CONTACTS:

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