

ATTENTION:RECOVERING IMPAIRED PHARMACIST PROGRAM ADMINISTRATOR  
INDIVIDUAL COUNSELING REPORT

\_\_\_\_\_ is required to have submitted on his/her behalf a counselor report and evaluation every \_\_\_\_\_ months. Please complete this form and return it to the address shown above.

Report On:

\_\_\_\_\_  
Name of Pharmacist, Intern, Pharmacy Technician Receiving Individual Counseling

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

Date Counseling Began: \_\_\_\_\_

Number of Sessions Attended Since Last Report: \_\_\_\_\_

Number of Sessions Missed Since Last Report: \_\_\_\_\_

Reasons Given for Absence: \_\_\_\_\_

Problem Areas Addressed In Counseling: \_\_\_\_\_

Is this Pharmacist, Intern, or Technician making satisfactory progress, is this individual demonstrating ability to make appropriate judgements, demonstrating cognitive functioning and stability to perform pharmacy functions? Yes\_\_ No \_\_

Comments: \_\_\_\_\_

Referrals or Recommendations Made To Pharmacist, Intern or Technician:

Compliance With Previous Recommendations: \_\_\_\_\_

\_\_\_\_\_  
Signature of Counselor

\_\_\_\_\_  
Agency

\_\_\_\_\_  
License/Registration Number

\_\_\_\_\_  
Address

( ) YES ( ) NO  
Certified/Chemical Dependency Counselor

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Telephone Number