

ATTENTION:RECOVERING IMPAIRED PHARMACIST PROGRAM ADMINISTRATOR

AFTERCARE REPORT

_____ is required to have submitted on his/her behalf an aftercare report and evaluation every month. Please complete this form and return it to the address shown above.

Report On:

Name of Pharmacist, Intern, Pharmacy Technician Attending Aftercare

Date of Report: _____

Date Joined Aftercare: _____

Number of Sessions Attended Since Last Report: _____

Number of Sessions Missed Since Last Report: _____

Reasons Given for Absence: _____

Problem Areas Addressed: _____

Is this Pharmacist, Intern, or Technician Making Satisfactory Progress: () Yes () No

Comments: _____

Referrals or Recommendations Made To Pharmacist, Intern or Technician:

Compliance With Previous Recommendations: _____

Signature of Aftercare Director/Facilitator

Title

Telephone Number

Agency

Address

City/State/Zip