Iowa Nurse Assistance Program (INAP)

Offered by the Iowa Board of Nursing
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AFTERCARE PROVIDER REPORT

REPORTS ARE DUE IN DECEMBER, MARCH, JUNE, AND SEPTEMBER OF EACH QUARTER

Participant Name: _____

Aftercare Provider Name (print): _____

Aftercare Provider Agency: _____

Aftercare Provider (signature): _____ Date: _____

Report Period: ☐ December ☐ March ☐ June ☐ September

Year: _____

Report Period:

from: _____ to: _____

Date of first Aftercare session: _____

Number of sessions attended since last report: _____

Number of sessions missed since last report and reasons: _____

_____

Is the participant making satisfactory progress?: ☐ Yes ☐ No

Has the participant taken an active and motivated role in his/her work with you?: ☐ Yes ☐ No

Is the participant gaining an understanding of relapse warning signs?: ☐ Yes ☐ No

Did the participant experience a relapse since the last report?: ☐ Yes ☐ No

Problem areas addressed or concerns of the client: _____

_____

Referrals or recommendations made to the client: _____

_____

For more information about INAP or to download forms, please visit our website:
https://nursing.iowa.gov/iowa-nurse-assistance-program

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