Iowa Nurse Assistance Program (INAP)

Offered by the Iowa Board of Nursing
400 SW 8th St, Suite B
Des Moines, Iowa 50309-4685
Phone: 515 725 4008
Fax: 515 725 4017
Email: INAP@iowa.gov

INTAKE FORM

Date: _____

General Information

First Name: _____ Last Name: _____

Date of Birth: _____

Home Address: _____

Phone Number: _____ Email Address: _____

Iowa License Number: _____

License Held in Other States: _____

How did you hear about INAP?: _____

Employment History

Years in Profession: _____ Present Employer: _____

Previous Employment History:

_____

_____

Information about employment discipline or termination:

_____

_____

Health History

List any substance abuse or mental health treatment (dates & diagnosis):

_____

_____

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

Health History (continued)

List any substance abuse or mental health hospitalizations (dates & diagnosis):

_____

_____

List current medications:

_____

_____

Doctor prescribing medications:

_____

Psychiatric history (past & present treatments, medications, and prescribers):

_____

_____

_____

Physical conditions or limitations (past & present treatments, medications, and prescribers):

_____

_____

_____

Alcohol and drug history (choice, attempts at treatment, last time of use, misused medications):

_____

_____

Family/Social History

Family/social history including use of alcohol/drugs:

_____

_____

Family/Social History (continued)

Support systems:

_____

_____

Legal History

Past or present arrests:

_____

_____

Convictions:

_____

_____

Action on licenses:

_____

Current status of professional license:

_____

Contact information for lawyer/officer, if involved:

_____

_____

_____

Emergency Information

Emergency Contact's name: _____

Address: _____

Phone Number(s): _____