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

SELF-REPORTING FORM

Fill out this form thoroughly and provide details.

Submit a copy of your substance use and/or mental health (co-occurring diagnosis) evaluation if you have one.

If you have not had a co-occurring evaluation, you will need to have one completed to be considered for INAP.

- **Personal & Licensure Information**

  Date of Report: _____

  Last Name: _____ First Name: _____

  Middle Name: _____ Date of Birth: _____

  Address: _____

  Email: _____

  Phone Number: _____ Alternative Phone Number: _____

  License Held in Other States: _____

  Status of Iowa Nursing License: _____

Does INAP have your permission to contact you at the above provided addresses and phone numbers? ☐ Yes ☐ No

If no, please specify: _____

_____

Are you currently being investigated by the Iowa Board of Nursing? ☐ Yes ☐ No

If yes, please explain: _____

_____

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

Has any action ever been taken against you by the Iowa Board of Nursing or any other state Nursing Booard? ☐ Yes ☐ No

If yes, please explain: _____

_____

- **Section One: Employment Information**

Are you currently employed as a nurse? ☐ Yes ☐ No

If yes, please provide immediate nursing supervisor/employer, contact name, and address: _____

_____

_____

Have any of your nursing employers ever submitted a complaint against you to the Board? ☐ Yes ☐ No

If yes, please explain: _____

_____

Please provide the name and contact information if working at a non-nursing job: ☐ N/A

_____

_____

Is your employer aware of your self-report to INAP? ☐ Yes ☐ No

- **Section Two: Healthcare Provider and Treatment Information**

Please provide the name and contact information of any provider prescribing medications: ☐ N/A

_____

_____

Please list ALL medications you are currently taking and the name of the prescribing doctor. ☐ N/A

_____

_____

Have you been evaluated by a professional for substance use or mental health?

☐ Yes ☐ No

If yes, please provide the name and contact information: _____

_____

_____

Have you received treatment for substance use or mental health? ☐ Yes ☐ No

If yes, please provide treatment dates and name of address of treatment provider (doctor, psychiatrist, etc): _____

_____

_____

_____

Have you received ongoing care for substance use and or mental health? ☐ Yes ☐ No

If yes, please provide the name and address of aftercare provider (counselor, therapist, etc.) _____

_____

_____

_____

Please provide the name and address of your medical provider:

_____

_____

- **Section Three: Entry Information**

  Some licensees may not be eligible for the INAP program.
  If you answer YES to any of the questions on the following page, please contact INAP before submitting this form.

Did you divert drugs to third parties for profit?

☐ Yes ☐ No

Did you adulterate/misbrand or tamper with drugs intended for patients?

☐ Yes ☐ No

Did you provide inaccurate, misleading, or fraudulent information or fail to fully cooperate with INAP?

☐ Yes ☐ No

Did you participate in the program or similar program offered by other states without success?

☐ Yes ☐ No

If you answered yes to any of the above items, please explain:

_____

_____

_____

_____

Are you a participant, or have you been a participant in another state's monitoring program? ☐ Yes ☐ No

If yes, provide details including: dates of participation, reason for enrollment, and disposition of your case. Attach additional documents, if necessary.

_____

_____

_____

_____

Please provide the details of why you are seeking entry into INAP. Be thorough and submit a detailed account. Attach additional documents, if necessary.

_____

_____

_____

_____

All information submitted to the Iowa Nurse Assistance Program regarding individual licensees is confidential.

Do you give INAP permission to inquire about the facts provided in this self-report?

☐ Yes ☐ No

- **Additional Information**

I understand that the terms of the nurse licensure compact may affect my ability to practice in another state on a compact license while participating in this program.

I understand I should not practice nursing in any other compact party state without first obtaining authorization from that party state.

I have read and understand the INAP *Fact Sheet* and am aware of program requirements.

I have completed the INAP intake form and submitted it.

I have completed and signed the release of information form.

I certify that all the information that I have provided is true and correct to the best of my knowledge.

_____ _____

SIGNATURE OF NURSE DATE