# Iowa Nurse Assistance Program (INAP)

Offered by the Iowa Board of Nursing
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## TREATMENT PROVIDER REPORT

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

**Participant Name:** _____

Primary Treatment Focus _____

Treatment Provider Name (printed): _____

Treatment Provider Agency: _____

Treatment Provider (signature): _____ Date: _____

Report Period: ☐ December ☐ March ☐ June ☐ September

Year: _____

Report Period:

from: _____ to: _____

| **Medication:** | **Dosage & Frequency:** | **Number of Refills:** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Participant's Current Diagnosis: _____

_____

_____

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

# TREATMENT PROVIDER REPORT

(CONTINUED)

Has there been any change in this participant's diagnosis?: ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Participant's treatment plan, recommendations, and interventions:

_____

_____

_____

_____

_____

_____

Has this participant experienced a relapse since the last reporting period?: ☐ Yes ☐ No

Is this participant working in their licensed profession?: ☐ Yes ☐ No

Has this participant changed jobs since the last reporting period?: ☐ Yes ☐ No

Practice Restrictions (if any): _____

_____

_____

List any concerns you may have about this nurse: _____

_____

_____

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