Iowa Nurse Assistance Program (INAP)
Self-Report Form

Iowa Nurse Assistance Program
400 SW 8th Street, Suite B
Des Moines, IA 50309-4685

Phone: 515-725-4008
Fax: 515-725-4017
Email: INAP@iowa.gov

***Please fill out this form thoroughly and submit a copy of your substance use and or mental health evaluation if you have one. If you have not had an evaluation, you will need to get one. ***

Last Name		First Name	
Middle Name		Date of Report	
DOB		Licenses held in other state	
Home Phone #		Cell Phone #	Other Phone #
Home Address			
Home Email			
Other Email			

Section One:

Does INAP have your permission to contact you at the above provided addresses?
_____

If no, please specify_____

Are you currently employed as a nurse? _____

If yes, please provide employer contact information_____
_____

Section Two:

Have you been evaluated by a professional for this condition? If yes, where and when?

Have you received treatment for this condition? Please provide treatment dates and name and address of treatment provider

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Please provide the name and address of aftercare provider

Please provide the name and address of recovery program monitor

_____

Please describe in detail the reasons for this self-report or events that led up to your report. Use a separate sheet if necessary and send any supporting documents.
Please list the chronological order of events:

Did you adulterate/misbrand or tamper with drugs intended for patients?
Did you provide inaccurate, misleading, or fraudulent information or fail to fully cooperate with INAP?
Did you participate in the program or similar program offered by other states without success?

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

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? _____

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

_____ _____
Signature Date

PLEASE RETURN TO:

Iowa Nurse Assistance Program

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