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

INAP PARTICIPANT QUARTERLY SELF ASSESSMENT: RETURN FORM TO INAP

PRINT NAME: DOB:	Quarter Ending: Dec 20 ☐ March 20 ☐ June 20 ☐ Sept 20 ☐
Address Change? ☐ No ☐ Yes (please update)	Employment Change: No ☐ or Yes ☐ (please update)
Effective Date:	Effective Date:
New Address:	Name of Employer: Worksite Name:
City: State: Zip:	Address: City: State: Zip:
Phone Change? ☐ No ☐ Yes (please update)	Position:
Home:	Schedule/ Hours:
Cell:	WSM email/phone Number:

Please list aftercare/recovery activities including meetings, group and individual counseling in past quarter:

INAP SELF ASSESSMENT (CONTINUED)

Describe challenges and successes in home/social life:

Describe challenges and successes in employment:

Please add anything additional about your recovery:

I have read and understand the information in this form.

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Print Name

____________________________________ ______________________

Signature Date

Thank you for your continued cooperation.