IOWA | Department of Inspections, Appeals, & Licensing

IOWA PROFESSIONAL HEALTH PROGRAMS

Quarterly Report - Worksite Monitor

Participant Name:	Worksite Monitor Name and Credentials:
	Contact Information:

Indicate which quarter this report covers:

☐ 1st Quarter ☐ 2nd Quarter ☐ 3rd Quarter ☐ 4th Quarter

How often are you meeting with the participant?	Daily	Weekly	Monthly	Quarterly

Dates of meetings:

Are you aware of any changes in the following? If yes, please explain below.	Yes	No
Attendance	☐	☐
Personal habits or general appearance	☐	☐
Practice performance	☐	☐
Interpersonal relationships	☐	☐
Social Behavior	☐	☐
Use of prescription/non-prescription drugs and/or alcohol	☐	☐

Please provide an explanation for your responses above:

Are you aware of any challenges the participant faced this quarter? Please explain.

Are you aware of any successes the participant had this quarter? Please explain.

Do you have any concerns about the participant? Please explain.

Do you have any concerns about the participant's ability to remain in active practice without affecting public safety? Please explain.
To the best of your knowledge, has the licensee had any restrictions to their practice and/or changes in their practice that may be affected by their impairment?
Would you like the IPHP staff to contact you? ☐ Yes ☐ No
Any further Comments, Questions or Concerns?
Worksite Monitor Signature: Date:

PROGRAM CONTACTS:

Department of Inspections, Appeals, & Licensing
ATTN: IPHP
6200 Park Avenue Suite 100
Des Moines, 50321-1270

Medicine	**Dental, Pharmacy, Professional Licensure**	**Nursing**
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