Iowa Nurse Assistance Program (INAP)
400 SW 8th St, Suite B
Des Moines, Iowa 50309

AFTERCARE PROVIDER REPORT

CLIENT'S NAME: ____

COUNSELOR NAME and TITLE: ____

AGENCY: ____

ADDRESS: ____

COUNSELOR SIGNATURE: ____

DATE: ______________________________ PHONE:________________________________

REPORT PERIOD: from _______________________ **to** _______________________________

This client is required through an Agreement with the Iowa Board of Nursing to submit this report every three months. It is the client's responsibility to allow you adequate time to complete and return this form. Your input is important to the monitoring process for this nurse. Please complete and return this to the address or fax below. Please notify INAP if you have concerns about this nurse.

Date of first Aftercare session: ____

Number of sessions attended since last report: _________________________________

Number of sessions missed since last report and reasons: _________________________

If absent, did the client inform you ahead of time in a responsible manner: ☐ Yes ☐ No

Is the client making satisfactory progress: ☐ Yes ☐ No

Has the client taken an active and motivated role in his/her work with you: ☐ Yes ☐ No

Is the client gaining an understanding of relapse warning signs: ☐ Yes ☐ No

Problem areas addressed or concerns regarding the client: __________________________

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Referrals or recommendations made to the client: _________________________________

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Please fax or mail completed form to INAP
Fax Number: 515-725-4017, Address: 400 SW 8th St, Suite B, Des Moines, IA 50309
For more information about INAP or to download forms, please visit our website at:
https://nursing.iowa.gov/iowa-nurse-assistance-program