State of Iowa
Out-of-State Substance Abuse Evaluation/Treatment Verification

Return this form to:

Iowa Department of Education
Attention: OWI
400 East 14th Street
Des Moines, IA 50319-0146
Fax: 515-725-2014
E-mail: OWIIowa@iowa.gov

Iowa law requires that individuals cited for operating a motor vehicle while under the influence of alcohol or drugs complete drinking driver education and a substance abuse evaluation.

This form is to be used by licensed substance abuse evaluators/treatment providers to document the results of a substance abuse evaluation/treatment. The state of Iowa reserves the right to not accept this form as proof of a substance abuse evaluation/treatment if it is not complete or contains false or misleading information. If you have questions regarding this form, you may call 515-281-5251 for assistance.

This form is being submitted to document:

- ☐ Substance Abuse Evaluation Only (complete Sections A, B, C & E)
- ☐ Substance Abuse Treatment Only (complete Sections A, D & E)
- ☐ Substance Abuse Evaluation & Treatment (complete all Sections)

Section A: OWI OFFENDER INFORMATION

Name: _____ (Last Name) _____ (First Name) ____ (MI) **Date of Birth:** _____ (mm/dd/yyyy)

Address: _____ **Telephone #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Email Address: _____

Section B: Substance Abuse Evaluator Information

_____ (Name of Facility) _____ (Name of Evaluator)

_____ (Address) _____ (Telephone Number)

_____ (City) _____ (State) _____ (Zip)

Is Facility and/or Evaluator a Licensed Substance Abuse Treatment Provider? ☐ Yes ☐ No

If yes, provide the following: _____ (Licensing Agency) _____ (Licensing Agency Contact Phone #)

_____ (License #) _____ (License valid until date)

Continued on back

Section C: Substance Abuse Evaluation

Date of Substance Abuse Evaluation: _____

What diagnostic tools were used for the evaluation?

Based on the evaluation, what recommendations did the Evaluator provide to the client?

Section D: Substance Abuse Treatment

If treatment was recommended, please complete the following:

_____ _____ Was treatment successfully completed? ☐ Yes ☐ No

Date treatment began Date treatment ended

Was treatment completed at the same facility as the evaluation? ☐ Yes ☐ No
If no, please complete the following:

_____
Name of Facility where Treatment was Completed

_____ _____
Address Telephone Number

_____ _____ _____
City State Zip

Is Treatment Facility a Licensed Substance Abuse Treatment Provider? ☐ Yes ☐ No

If yes, provide the following: _____ _____ _____
Licensing Agency License # License valid until

Section E: Signature

I attest that the information provided on this form is true and accurate.

_____ _____
Name of person completing form *Signature of person completing form*

_____
Title