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

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

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: ___________________________ Date of Birth: ____________ (mm/dd/yyyy)

Last Name: ___________________________ First Name: ___________ MI: ____

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: ___________________________

Return this form to:

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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:

Date treatment began ______________________ Date treatment ended ______________________

Was treatment successfully completed?  ☐ Yes  ☐ No

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 ______________________