

# State of Iowa

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

**Return this form to:**

Iowa Department of Education  
Attention: OWI  
400 East 14<sup>th</sup> 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.

- 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:** \_\_\_\_\_  
Last Name First Name MI (mm/dd/yyyy)

**Address:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

### Section B: Substance Abuse Evaluator Information – *this section is to be completed by the evaluator*

\_\_\_\_\_  
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 - *this section is to be completed by the evaluator***

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