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

Return this form to:

Iowa Department of Education
Attn: OWI
400 East 14th Street
Des Moines, IA 50319-0146
Fax: 515.242.5988
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)

Social Security #: _____ **IDOT Customer # if Known:** _____
*This number can be obtained by calling the IDOT at 515-244-8725

Address: _____ **Telephone #:** _____

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

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

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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:

_____ _____ 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