



Iowa State Police Association Officer Assistance Program

Confidential

ASSISTANCE REQUEST FORM

Donation: \$ _____

Member Since: _____

Local #: _____

FOR OFFICE USE

DATE OF INCIDENT / INJURY: _____

APPLICANT CELL PHONE #: _____

APPLICANT NAME: _____ DATE OF BIRTH: _____

HOME ADDRESS: _____

CITY/STATE/ZIP: _____ EMAIL: _____

SPOUSE NAME: _____

CHILDREN'S NAMES & AGES: *(Living in the home)*

AGENCY: _____ JOB TITLE: _____ DATE OF HIRE: _____

SUPERVISOR: _____ WORK PHONE #: _____

REASON FOR REQUEST: *(describe need and nature)*

Amount Requested \$ _____ (\$100 minimum to \$1,250 maximum)

REFERRING PERSON INFORMATION

NAME: _____ CELL#: _____

JOB TITLE: _____ AGENCY: _____ WORK PHONE #: _____

ISPA MEMBER: Yes _____ No _____ E-MAIL ADDRESS: _____

Please submit completed form to Ispaonline@gmail.com with Subject Line: Officer Assistance Program