

PEER ASSISTANCE PROGRAM
2901 N. Classen Blvd., Suite 101
Oklahoma City, OK 73106

OKLAHOMA BOARD OF NURSING
405/525-2277
Fax 405/525-0350

www.ok.gov/nursing

REPORT/SUMMARY OF SPONSOR CONTACT

(Must be received in the office by the 5th of each reporting month)
(Reporting months: February, May, August, and November)

CLIENT NAME _____

DATE DUE _____

I release to the Peer Assistance Program the information required below:

Client Signature

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Length of time you have been client's sponsor _____

Frequency of contact _____

Showing progress in program _____

Compliance with suggestions _____

Comments/Concerns _____

Sponsor's Signature
(First name, last initial)

Sponsor's Telephone Number