NURSE SUPPORT GROUP FACILITATOR REPORT

(Reports are due in the program office on the 5th day of February, May, August and November)

Participant: ___________________________ Reporting Months __________

1. Absences in the past quarter?

2. Fees are current?  Yes  No  (please circle choice)

3. Group participation: Active _____ Attentive _____ Distracted _____

4. To your knowledge has the participant been abstinent this past quarter?
   Yes  No  (Please circle choice. If no, please address below.)

5. The participant ___________ (Please circle choice)
   A. Expresses a desire for recovery.
   B. Exhibits behaviors consistent with recovery.
   C. None of the above.

6. Comments/Recommendations for the Peer Assistance Committee? __________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Facilitator Signature _______________________________  Date __________