NURSE SUPPORT GROUP FACILITATOR REPORT

(Reports are due in the program office on the 5th day of January, April, July, October)

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?
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
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_____________________________ ________________________
Facilitator Signature Date