PEER ASSISTANCE PROGRAM OKLAHOMA BOARD OF NURSING
2901 N. Classen Blvd., Suite 101 405/525-2277
Oklahoma City, OK 73106 Fax 405/525-0350
www.nursing.ok.gov

REPORT/SUMMARY OF SPONSOR CONTACT

(Must be received in the office by the 5th of each reporting month)
(Reporting months: January, April, July, October)

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 Sponsor's Telephone Number
(First name, last initial)