

PEER ASSISTANCE PROGRAM
P.O. Box 52926
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OKLAHOMA BOARD OF NURSING
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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?

Facilitator Signature

Date