



The Commonwealth of Massachusetts
Department of Public Health
Bureau of Health Professions Licensure

Board of Registration in Nursing
239 Causeway Street • Boston, Massachusetts 02114

Substance Abuse Rehabilitation Program
Monitoring Documentation Checklist

Date _____

Participant (please print) _____

Email address: _____

Please turn in this Check List along with your Monitoring Documentation each quarter. Check below the documents that you are turning in and give a brief explanation if a document is incomplete or missing.

Individual Therapist Report _____

Professional Support Group _____

Self- Help Report _____

Job Performance Progress Report _____

Contract Change Request _____

Self-Help Meeting Report _____

Health Care/ Medication Report Form _____

Psychiatrist Report (if applicable) _____

(9) Contact Hours in substance abuse _____

Please complete, if currently working.

Employer's name and address _____

Supervisor's name _____ Phone number _____
