



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
Peer Support Group

Please complete this Report on a regular basis, as stipulated in the Consent Agreement for SARP Participation (CASP) and return it directly to the SARP Coordinator during each scheduled monitoring meeting.

Name of Nurse in SARP (please print) _____

Date of Report: _____ Report due: _____

Date joined group: _____

Frequency of therapy: [] Weekly [] Bi-weekly [] Monthly [] Other _____

Have you read the Consent Agreement for SARP Participation between the SARP Participant and SARP? [] Yes [] No Comments: _____

Do you have any questions regarding this Consent Agreement for SARP Participation?
 [] Yes [] No Comments: _____

Dates of sessions attended since last Report:

Dates

Dates of sessions missed since last Report:

Date

Reason for Absence

Date	Reason for Absence

