The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

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SARP Report: Individual Therapist/Treatment Provider

Please complete and return this Report as stipulated in the Consent Agreement for SARP Participation (CASP). This report may be faxed to (617)887-8786. Please attach additional sheets as necessary.

SARP Participant Name:	
Therapy Session Frequency:	☐Weekly ☐ Bi-weekly ☐Monthly ☐ PRN

Dates of Attendance				**Missed Sessions**			
				Date(s)	**Reason(s)**	**Session Rescheduled**	**Date Completed**
						☐Yes ☐No	
						☐Yes ☐No	
						☐Yes ☐No	
						☐Yes ☐No	
						☐Yes ☐No	

1.Are you familiar with the Participant's Consent Agreement for SARP Participation? ☐Yes ☐No
2.Is the participant making satisfactory progress? ☐Yes ☐No
3.Have there been any breaks in abstinence since the last quarterly report? ☐Yes ☐No
4.Have you been informed of any SARP non-compliance matters? ☐Yes ☐No
5.Is there anything you with to speak with SARP staff about? ☐Yes ☐No

Comments section for questions 1-4:

What are the Participant's treatment goals and objective, and educational needs?

If it applies, please share treatment plan recommendations:

Additional Comment Space

Do you have recommendations that the participant:

1. Reduces the amount of therapy sessions per month? ☐Yes ☐No
2. Reduces the amount of group meetings per week? ☐Yes ☐No
3. Return to nursing practice? ☐Yes ☐No

*If yes to any of the questions above, please send or fax a letter of recommendation citing the request and rationale on letterhead that is signed and date. The recommendation may be faxed to **(617)887-8786.** Please note the following:

- Therapy shall not be reduced to less than an "as needed/ PRN" basis.

Please refrain from giving this quarterly report and letters of recommendation to the participant to submit to SARP staff. The SARP anticipates all reports being sent directly to the SARP by the individual completing the report/letter(s).

Therapist Name:		Lic. Type and #:	
# Years working w/ participant:		Years of practice:	
Do you hold a substance use disorder counseling license/cert?		☐No ☐ LADCI-II ☐CADCI-II Other:	
Agency Name or Independent Practice:		Phone:	
Address:			

Signature Date Signed

Form Revised: 3/13/23