SARP: Individual Therapist/Treatment Provider Report

Please complete and return this Report as stipulated in the Consent Agreement for SARP Participation (CASP).

Name of Participant in SARP (please print): ____________________________________________________________

Frequency of therapy sessions:

[ ] Weekly  [ ] Bi-weekly  [ ] Monthly  [ ] PRN  [ ] Other: __________________________

Dates of sessions attended since last Report:

<table>
<thead>
<tr>
<th>Date</th>
<th>Reason for Absence</th>
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Dates of sessions missed since last Report:

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<th>Date</th>
<th>Reason for Absence</th>
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1. Have you read the Participant’s Consent Agreement for SARP Participation (CASP)?  [ ] Yes  [ ] No

2. Is the Participant making satisfactory progress?  [ ] Yes  [ ] No  [ ] Unsure

3. Have there been any breaks of abstinence since the last Report?  [ ] Yes  [ ] No  [ ] Unsure

Comments section for questions 1, 2, and 3:

______________________________________________________________________________

______________________________________________________________________________

Please keep copy for your records
4. New or Additional Compliance Concerns Since Last Report: [ ] None

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

5. What is the Participant’s treatment goals and objectives?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

6. If it applies, what are the participant’s education plans?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

7. As it applies, please share your recommendations for this participant (please attach additional documents as needed):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Name of Therapist/Counselor (please print) ________________________________
License#/Registration#/Certification#: ______________________________________
Agency: ___________________________ Telephone: ___________________________
E Mail: __________________________
Address: __________________________
City: _____________________________ State: ______ Zip: ________________________
Type of Degree(s): ___________________________ Date(s) received: ________________
Length of time in practice: ________________________________________________
Are you a Certified Chemical Dependency Counselor [ ] Yes [ ] No
Type of Certification: ___________________________ Date received: ________________

Signature of Therapist/Counselor _______________________________ Date Signed ________________

This report may be mailed to the address found in the letterhead or faxed to (617)887-8786.