



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
Individual Therapist/Treatment Provider Report

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) _____

Frequency of therapy sessions:

Weekly Bi-weekly Monthly PRN Other _____

Dates of sessions attended since last Report:

Dates

Dates of sessions missed since last Report:

Date

Reason for Absence

Date	Reason for Absence

Length of time working with the SARP Participant: _____

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: _____

Treatment Plan:

Individual therapy goals and objectives: _____

Education Plan: _____

Is the Participant's family/partner involved in treatment? [] Yes [] No

Comments: _____

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

Comments: _____

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

Comments: _____

Additional Comments: _____

Recommendations: _____

Name of Therapist/Counselor (please print) _____

License # / Registration # / Certification #: _____

Agency: _____ Telephone: _____

Address: _____

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 of Report