



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
Self Assessment Report

Name (please print) _____ Date: _____

Date entered SARP: _____

Instructions: The purpose of this self-report is to provide you with a way to inform the SARP how you think you are doing in your recovery process. It also offers you an opportunity to identify problem areas where additional assistance may be needed. Please share your views as the SARP appreciates your response.

Please list below any changes in your address, name and/ or telephone number:

Name: _____

Address: _____ Phone # _____

- I have mailed or faxed or emailed my request to change my address to the Board or changed on-line.
- I have mailed my request to change my name with legal documentation for the name change to the Board.

How many AA/NA meetings are you attending? _____

Who is your sponsor? Home Group? _____

What professional support group are you attending? _____

Have you had any recent medical/surgical/psychiatric problems? Are you taking any medication(s)?

Yes No Comments: _____

Have you obtained or changed your primary care physician/provider? Yes No

If yes, Name: _____ Address: _____

Are you currently employed in Nursing? Yes No

Name and address of current employer(s)

Have you changed employers or changed your role in the employing facility since your last self-report?

Yes No If yes, describe _____

Name and title of supervisor responsible for overseeing your nursing practice: _____

Are you employed outside of nursing? Yes No If yes, in what capacity?

Describe any major changes in your life: _____

Describe any problems you are having following your Consent Agreement for SARP participation.

Describe what progress you have made in your recovery. _____

Can SARP assist you in anyway? _____

I understand that in submitting this self-report, I give Massachusetts Board of Registration in Nursing Substance Abuse Rehabilitation Program (SARP), permission to release information regarding my participation in the SARP to the therapist(s), employer(s) and /or physician(s) named herein.

SARP Participant Signature

Date