



INDIANA STATE NURSES ASSISTANCE PROGRAM
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 www.IndianaNurses.org

ADDICTIONIST'S QUARTERLY REPORT

Thank you for your assistance with monitoring. Your input is invaluable to ISNAP. Please be assured that this form is confidential and not available to anyone outside of the monitoring program.

Thank you for your cooperation.

Licensee's Name: _____

Months of: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Year: _____
(Please circle the 3 months of the Quarter)

- To the best of your knowledge, is the Licensee:
 Remaining Clean and Sober? No Yes
 Compliant with his/her Recovery Monitoring Agreement (RMA)? No Yes
 Attending the required AA/NA/Nurse Support Meetings? No Yes
 Working a solid recovery program? No Yes
 Have you observed any signs of relapse? No Yes

- Do you have any suggestions for improving Licensee's recovery plan/quality of life? No Yes
If YES – Please add suggestions:

- Are you supporting any changes in his/her RMA at this time? No Yes If yes, please explain

- If on medication(s), is Licensee being compliant with prescribed medication(s)? No Yes
 Are there any medication changes at this time? No Yes

- Is there any reason to believe that this Licensee is NOT safe to practice his/her profession safely and competently? No Yes If yes, please explain

- Would you like someone from ISNAP to contact you? No Yes

- Has Licensee reported any relapses during this quarter? No Yes

Addictionist's Name: _____ Contact #: _____

Facility Name/Address: _____

 Addictionist's Signature:

 Date: