



INDIANA STATE NURSES ASSISTANCE PROGRAM
 2915 N. High School Rd., Indianapolis, IN 46224
 (317) 295-9862 • (800) 638-6623 • Fax (317) 297-3525
 www.IndianaNurses.org

SPONSOR'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)

1. How long have you been Licensee's Sponsor? _____

2. How often do you have contact with this person that you sponsor? _____

3. To the best of your knowledge, is the Licensee:
- Compliant with his/her Recovery Monitoring Agreement (RMA)? No Yes
 - Attending his/her AA/NA/Nurse Support Meetings? No Yes
 - Working a solid recovery program? No Yes
 - Displaying any signs of relapse? No Yes

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

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

6. Is there any reason to believe that this Licensee is NOT safe to practice their profession safely and competently? No Yes

7. Has Licensee reported any relapses during this quarter? No Yes

8. Would you like someone from ISNAP to contact you? No Yes

 Sponsor's Signature:

 Contact #:

 Date: