



THE THERAPIST'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. To the best of your knowledge, is the Licensee:

Remaining Clean and Sober?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Compliant with his/her Recovery Monitoring Agreement (RMA)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Attending the required AA/NA/Nurse Support Meetings?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Working a solid recovery program?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Have you observed any signs of relapse?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

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

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

4. How much longer do you feel that this Licensee will continue in therapy? _____
5. Would you make any recommended changes in the therapy program? No Yes
6. Is there any reason to believe that this Licensee is NOT able to return to work? 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

Therapist's Name: _____ Contact #: _____

Facility Name/Address: _____

 Therapist's Signature: _____ Date: _____