

PEER ASSISTANCE PROGRAM
2915 N. Classen Blvd., Suite 215
Oklahoma City, OK 73106

OKLAHOMA BOARD OF NURSING
405/525-2277
Fax 405/525-0350

www.ok.gov/nursing

Instructions:

- To be completed by the Peer Assistance Program participant
- Complete entire form. Refer to Self-Assessment Report Guidelines.
- Attach Support Group Attendance Logs.
- Forms must be signed by the participant.
- Submit to program office by the 5th day of month due.

SELF-ASSESSMENT REPORT

Reporting Month(s) _____

Name _____ License # _____

*Address _____

Telephone Number (____) _____

(*If the above address or phone number has changed, since last report, this must be reported to the program on the appropriate form and also to the Board of Nursing.)

1. Date Peer Assistance Program contract signed: _____

2. Sobriety date: _____

3. Have you had a relapse this reporting period? Yes No If yes, please address what happened and actions taken. _____

4. Have you reviewed your contract/amended contracts with the program? Yes No

5. Do you continue to abide by its terms and conditions? Yes No If no, please explain what problems you are having in following your contract/amended contracts. _____

6. Have you had any health related issues this reporting period? (ex.: medical procedures, medication changes, use of narcotics, etc.) Yes No If yes, please explain. _____

Self-Assessment: (name) _____

Therapy Attendance and Involvement

1. Type of therapy currently required: (check all that apply) <input type="checkbox"/> Aftercare <input type="checkbox"/> Individual Counseling <input type="checkbox"/> Inpatient <input type="checkbox"/> IOP <input type="checkbox"/> Outpatient <input type="checkbox"/> None Other (please specify): _____
2. Therapist name and title: _____
3. How long have you been in counseling with this individual? _____
4. What is your current treatment plan? _____ _____ _____
5. Number of sessions scheduled this reporting period? _____
6. Number of sessions attended this reporting period? _____
7. Have we received the required reports for this period? (i.e.: progress report; discharge summary; aftercare plan) <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what efforts have you made to see these reports are submitted? _____ _____ _____
8. Comments regarding progress: _____ _____ _____ _____ _____

Nurse Support Group Attendance and Involvement

1. Name of facilitator _____
2. Number of meetings required this reporting period _____ Number attended _____
3. Comments: (what are you getting/giving to the group? Why have you missed meetings?) _____ _____ _____ _____

Self-Assessment: (name) _____

12-Step Meeting Attendance and Involvement

1. Do you have a sponsor? <input type="checkbox"/> Yes <input type="checkbox"/> No Sponsor's first name & last initial _____
2. Frequency of contact: Face-to-face _____ Phone _____
3. What step are you working on? _____ What does this step mean to you? _____ _____ _____
4. Number of meetings required this reporting period: _____ Number attended: _____
5. Name & location of home group: _____
6. Service involvement/other progress: _____ _____ _____

Employment

Employer: _____
Address: _____
Telephone number: _(_____) _____
Job title: _____ How long have you been with this employer? _____
Hours worked per week: _____ Duty hours: _____
Did you work any overtime this reporting period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours? _____
Do you have narcotic privileges? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please address any problems/concerns/accomplishments in the workplace: _____ _____ _____
If unemployed in nursing, please address your attempts to find nursing employment (where have you applied, interviews, etc): _____ _____ _____

