PEER ASSISTANCE PROGRAM
P.O. Box 52926
Oklahoma City, OK 73152
OKLAHOMA BOARD OF NURSING
405/525-2277
Fax 405/525-0350
http://www.oklahoma.gov/nursing

REPORT/SUMMARY OF SPONSOR CONTACT
(Must be received in the office by the 5th of each reporting month)
(Reporting months: January, April, July, October)

CLIENT NAME ____

DATE DUE ____

I release to the Peer Assistance Program the information required below:

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Client Signature

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Length of time you have been client's sponsor ______________________

Frequency of contact ______________________

Showing progress in program ______________________

Compliance with suggestions ______________________

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Comments/Concerns ______________________

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______________________ Sponsor's Signature
(First name, last initial)

______________________ Sponsor's Telephone Number