ARIZONA STATE BOARD OF NURSING
ALTERNATIVE TO DISCIPLINE
1740 WEST ADAMS STREET, SUITE 2000
PHOENIX, ARIZONA 85007-2607
TELEPHONE (602) 771-7865
Program email: ATD@azbn.gov

INDIVIDUAL OR GROUP COUNSELING

CLIENT'S NAME: _____

THERAPIST'S NAME: _____ AGENCY: _____

ADDRESS: _____ PHONE: _____

THERAPST'S SIGNATURE: _____ DATE: _____

REPORT PERIOD: from _____ to _____

This client is required through an Agreement with the Arizona State Board of Nursing, to submit this report every 2 months. It is the client's responsibility to allow you adequate time to complete and return this form. Your input is important to the monitoring process for this nurse. Please complete this form and return it to the address, fax or email above.

Date of first counseling/therapy session: _____

Number of sessions attended since last report: _____

Number of sessions missed since last report and reasons: _____

If absent, did the client inform you ahead of time in a responsible manner: ☐ Yes ☐ No

Is the client making satisfactory progress? ☐ Yes ☐ No

Goals you and the client are actively working toward: _____

_____

_____

_____

Referrals or recommendations made to the nurse: _____

_____

_____

Compliance with previous referrals or recommendations: _____

_____