

**ARIZONA STATE BOARD OF NURSING  
CANDO PROGRAM  
4747 NORTH 7TH STREET, SUITE 200  
PHOENIX, ARIZONA 85014-3655  
(602) 771-7865      FAX (602) 771-7882**

**AFTERCARE REPORT**

CLIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
COUNSELOR: \_\_\_\_\_ AGENCY: \_\_\_\_\_  
TITLE: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
TIME PERIOD FOR THIS REPORT:      FROM: \_\_\_\_\_      TO: \_\_\_\_\_

This client is required by the Arizona State Board of Nursing CANDO Program, a diversion program, to submit an aftercare report on a periodic basis. It is the client's responsibility to allow you adequate time to complete and return this form. Your input is vital to the monitoring process of this individual. Would you please thoughtfully complete this form and return it to CANDO in a timely manner. You may choose to complete it with your client in attendance.

Date joined aftercare: \_\_\_\_\_

Number of sessions attended since last report: \_\_\_\_\_

Number of sessions missed since last report: \_\_\_\_\_

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

Has the client taken an active and motivated role in his/her work with you:  
Yes \_\_\_\_\_ No \_\_\_\_\_

Does the client show evidence of regular attendance in a 12-step program:  
Yes \_\_\_\_\_ No \_\_\_\_\_

Is the client gaining an understanding of relapse warning signs:  
Yes \_\_\_\_\_ No \_\_\_\_\_

Does the client have a positive attitude toward being in your program:  
Yes \_\_\_\_\_ No \_\_\_\_\_

***CONTINUED ON BACKSIDE \****

Have you been aware of any signs of depression or suicidal thoughts:

Yes \_\_\_\_\_ No \_\_\_\_\_

To the best of your knowledge, do you believe the client is maintaining abstinence from all mind altering or addictive chemicals, including alcohol:

Yes \_\_\_\_\_ No \_\_\_\_\_

Please comment or describe any concerns you have regarding the client at this time and your recommendations regarding these concerns:

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Counselor Signature