

**ARIZONA STATE BOARD OF NURSING  
CANDO PROGRAM  
4747 North 7th Street, Suite 200  
Phoenix, Arizona 85014-3655  
(602) 771-7865      FAX (602) 771-7882**

**SELF-REPORT FORM**

This form is to be used by all participants in the CANDO Program whether employed in nursing or not. Many of the questions are designed as an aid to help you think about your recovery program and plan.

PARTICIPANT: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

**REPORTING PERIOD:**                      **From:** \_\_\_\_\_                      **To:** \_\_\_\_\_

CURRENT HOME ADDRESS IF MOVED SINCE LAST REPORT:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

EMPLOYER: \_\_\_\_\_

SUPERVISOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

NURSE RECOVERY GROUP FACILITATOR: \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS AS THOUGHTFULLY AS YOU CAN.**

1. Have you attended all rehabilitation, aftercare, individual and/or group counseling and nurse recovery meetings this reporting period?    Yes \_\_\_\_\_    No \_\_\_\_\_    If you have answered no, please explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. If employed, please describe how you feel at work. How have your relationships with co-workers been, have there been any incidences that have concerned you, and any positive feedback from supervisors.

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3. Describe your present personal recovery program.

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4. What do you see as the strengths and weaknesses of your program?

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5. When faced with stressful events since the last reporting period, what have been the coping skills you have utilized?

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6. Describe your support system at this time.

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7. Describe something you have learned about yourself during this reporting period.

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8. Is there anything in particular you would like to comment about regarding the CANDO Program and specific needs you may have at this time.

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9. Medications taken during this reporting period, the date taken, reason taken, name and phone number of filling pharmacy, and authorizing health care provider are to be listed below. Use an additional sheet if necessary and specify date, time, and amount of any PRN medications. All medications except plain Aspirin, Tylenol, and Ibuprophen, must be authorized by your health care provider including over-the-counter medications, vitamins and minerals are not considered medications. All potentially addictive medications must be authorized **monthly** by your health care provider.

Date	Reason/Medication	Pharmacy	Health Care Provider
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			

Signature: \_\_\_\_\_

Date: \_\_\_\_\_