FORM W

Ohio Board of Nursing *www.nursing.ohio.gov*
17 S. High Street, Suite 660 • Columbus, Ohio 43215-3466 • 614-466-3947

PROGRESS EVALUATION FORM

Please submit this form directly to the Ohio Board of Nursing's Alternative Program for Chemical Dependency/Substance Use Disorders by mail or by fax (#614-466-0710).

Report for the month/year of: _____ Participant Name: _____

Evaluator Name: _____ Title: _____

Agency Name: _____Phone: _____

Service(s) Provided to Participant: _____

Please rate the Participant using the scale indicated below:
5= Excellent and 1= Poor

	RATING	COMMENTS
Attendance at Sessions	5—4—3—2—1	
Participation at Sessions	5—4—3—2—1	
Problem Solving Ability	5—4—3—2—1	
Support Systems	5—4—3—2—1	
Compliance with Treatment Plan	5—4—3—2—1	
Understanding and Integration of Treatment Plan	5—4—3—2—1	
Progress in Treatment	5—4—3—2—1	
Stability in Recovery	5—4—3—2—1	

ADDITIONAL COMMENTS:

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_____ _____

Signature of Treatment Provider/Title Date

Effective April 2015