MIDWEST HEALTH MANAGEMENT SERVICES, LLC

HEALTH PROFESSIONALS ASSISTANCE PROGRAM

4109 S. Carnegie Circle Sioux Falls, SD 57106
Phone: 605-275-4711 • Fax: 605-275-4715

SPONSOR/MENTOR/RECOVERY COACH QUARTERLY STATEMENT

Please ask your sponsor/recovery coach to complete a statement below.
Submit this report every quarter.

Name of Participant: _____

Reporting Period: from _____ to_____

The Participant's progress is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Comments: _____

_____

_____

_____

Signature of Sponsor/Mentor/Recovery Coach: (First Name Only) _____

Date: _____