

SOUTH DAKOTA HEALTH PROFESSIONALS ASSISTANCE PROGRAM

3130 West 57th Street #111 ♦ Sioux Falls SD 57108
Tel: (605) 275-4711 ♦ Fax: (605) 275-4715

SPONSOR QUARTERLY STATEMENT

Please ask your sponsor 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: (First Name Only) _____

Date: _____