



## Verification of Meeting Attendance

The signing of this form indicates that the patient listed below has completed one full NA or other group meeting.

Patient name (please print): \_\_\_\_\_

Name of Facilitator (please print): \_\_\_\_\_

Signature of Facilitator: \_\_\_\_\_

### Date, Time & Location of Meeting:

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

Location: \_\_\_\_\_