Eastern Missouri Alternative Sentencing Services
Community Support Meeting Verification Report

Client Name:________________________

Group Name:________________________

Date:____________ Time:______________

Meeting Location:_________________________

Is this meeting your home group: ☐ Yes ☐ No

Type of CS Meeting	Meeting Format (Check all that apply)
☐ Alcoholics Anonymous	☐ Open
☐ Cocaine Anonymous	☐ Closed
☐ Marijuana Anonymous	☐ Discussion
☐ Narcotics Anonymous	☐ Speaker
☐ Celebrate Recovery	☐ Step
☐ Other:____________	☐ Big Book
	☐ Basic Text Study
	☐ Gender Specific

What was the subject of the meeting? ___________________________________

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What did you learn in the meeting?_____________________________________

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How did you benefit by attending the meeting?_____________________________

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What in the talk or comments applies to you?_____________________________

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Did you share? ___Yes ___No

Client Signature: ___________________________________

Chairperson's Signature: _____________________________