FACILITY RECOVERY PLAN

State Form 46493 (3-94)

Department of Correction
Substance Abuse Program

Name of facility	
Name of client / offender	DOC number

The following recommendations are made as this individual's facility recovery plan:

If further information is needed, the substance abuse counselor may be contacted.

Signature of client/offender	Date signed *(month, day, year)*
Signature of substance abuse counselor/clinician	Date signed *(month, day, year)*

DISTRIBUTION: **White -** Offender packet; **Pink -** Offender