GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

GEORGIA BOARD OF PHARMACY
TREATMENT PROVIDER OF IMPAIRED PHARMACIST/INTERN
QUARTERLY REPORT FORM

ALL reports should be mailed to the Board office for reporting periods ending March 31st, June 30th, September 30th, and December 31st.

Report for quarter ending: _____

Name of Licensee: _____ License #: _____

Treatment Program/Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

The above-referenced individual has:

Attended _____ group meetings each month.

Submitted _____ random observed drug screens this quarter. **Results must be attached.**

Significant changes in this individual's treatment/aftercare program during this quarter

are as follows: _____

_____

_____

Additional comments: _____

_____

_____

Report submitted by: _____
(Print full name)

Signature: _____ Date: _____

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