



**GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH**

**GEORGIA BOARD OF PHARMACY  
EMPLOYER QUARTERLY REPORTING FORM**

Instructions to employer: Please complete this form to assist the Board of Pharmacy in monitoring the practice of this pharmacist. **ALL** reports should be mailed to the Board office by reporting period ending March 31<sup>st</sup>, June 30<sup>th</sup>, September 30<sup>th</sup>, and December 31<sup>st</sup>.

Reporting Period \_\_\_\_\_ Supervisor's Name \_\_\_\_\_

Name of Licensee \_\_\_\_\_ License Number \_\_\_\_\_

Name of Pharmacy \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Licensee's: Position \_\_\_\_\_

Schedule \_\_\_\_\_

Categories	Comments
Attendance	
Quality of Work	
Attitude	
Number of Hours Worked	

Additional Comments \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature of Preparer \_\_\_\_\_

Printed Name of Preparer \_\_\_\_\_

Title of Preparer \_\_\_\_\_

Date \_\_\_\_\_