



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

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 Number: _____

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: _____