PRO Inc.
Pharmacists Rehabilitation Organization Inc.

Client Information

Assigned Client# _____

Name:

Street Address	City	State	Zipcode

Phone: Home		Social Security #	
Phone: Cell		Ohio Pharmacist License #	
Phone: Work		Other State(s) License #	
Email Address		Sobriety Date	

State Board Involvement? YES _____ NO _____

Quarterly Reports need to be sent to the Board of Pharmacy? YES _____ NO _____

P.R.O. Advocate Information:

Name:

Street Address	City	State	Zip code

Home Phone	Cell Phone	Work Phone	Email Address