KENTUCKY PHYSICIANS HEALTH FOUNDATION
MONTHLY REPORT FORM

DATE: ____________________ REPORT FOR MONTH OF: ______________________

NAME: ____

EMAIL: ____

PLEASE UPDATE ANY NEW INFORMATION:
Phone numbers (home, cell, or work), email address, home or work address
(Only list information here if it is new since last month)

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DRUG(S) OF CHOICE____

LAST USE/SOBRIETY DATE____

ALL MEDICATIONS (including OTC and supplements) TAKEN THIS MONTH:

PLEASE UPDATE THE FOLLOWING AREAS: (Required)

WORK/SCHOOL:

FAMILY:

SELF:

SPONSOR: PHONE NO:

NUMBER OF MEETINGS (AA, SA, NA) ATTENDED THIS MONTH: ____________

YOUR MEETINGS MUST BE LISTED ON A SEPARATE SHEET OF PAPER: List date, time, name of meeting, location, and first name of chairperson. Sponsor MUST sign meeting list.

THIS FORM MUST BE COMPLETED EACH MONTH AND ATTACHED TO YOUR MEETINGS LIST!