Thank you.

We have received the following information:

Your First Name:	Leo	Your Last Name:	Stoller
Mailing Address 1:	P.O. Box 60645	Mailing Address 2:	
City:	CHICAGO	State:	IL
Zip:	60660		
Your E-mail Address:		Ldms4@hotmail.com	
Day Telephone No:		3125454554	
Evening Telephone No:			

YOUR COMPLAINT IS AGAINST (RESPONDENT) :

Professional's First Name:	Eric	Professional's Last Name or Name of Business:	Reid

Profession:	PHARMACIST, REGISTEREDREGISTERED PHARMACIST
Street address (1st line):	5205 N, Broadway
Street address (2nd line):	

City:	Chicago	State:	IL
Zip code:	60640	Telephone No:	773-275-5641
Date Event Occurred:	02/22/023	County Where Occurred:	Cook

DESCRIPTION OF COMPLAINT:

Complaint to Cancel the Pharmacy License 051294673 of Eric Reid