Department of Health
Health Professional Licensing Administration
Board of Pharmacy
899 North Capitol Street, NE
2nd Floor
WASHINGTON, DC 20002

PHARMACY EDUCATION AND TRAINING SUPPLEMENTAL INFORMATION FOR RECENT GRADUATES ONLY

*Existing licensed Pharmacists are not required to have this form completed.

NAME:	TYPE OF LICENSE:	THIS FORM SHOULD BE COMPLETED BY: PHARMACIST
ADDRESS:	DATE OF APPLICATION:	

1. Pharmacy College Affidavit.

This is to certify that ____attended the

____College of Pharmacy.

From _________________________To _______________________________

From _________________________To _______________________________

From _________________________To _______________________________

From _________________________To _______________________________

And on _________________________was graduated from the ________year course with the degree

of___________________________________.

(SEAL OF COLLEGE)

____
(Signature of Dean or Registrar)

____
(Address)

2. Affidavit as to character.

I, the undersigned, know _________________________to be of good and moral character, not addicted to use of alcoholic liquor or narcotic drugs and worthy to be licensed pursuant to law.

____
(Signature)

Subscribed and sworn to before me by ____

This _______________day of___________________,20____.

Witness my hand and seal this _______________day of _____________, 20____.

(Seal)

____
(Notary)