

VERIFICATION OF LICENSURE

To be completed by applicant prior to mailing to each state in which you now hold or have ever held a license to practice. Please print. (This form may be copied as necessary.)

Applicant

Name: _____

Address: _____

(state)

(zip code)

License #: _____ Date Issued: _____

I hereby authorize the Board of Pharmacy of the State of _____
to furnish to the Maine State Board of Pharmacy the information requested below.

Applicant Signature: _____

Date: _____

To be completed by the State Licensing Board verifying the above information. Please complete this section and return to the applicants address above:

LICENSING BOARD OR AGENCY: This is to certify that the above-named was issued:

License #

Date issued

Date of expiration

Current Status of License: (check all that apply) Active Inactive Lapsed
Probation Restricted Suspended Revoked

Disciplinary Action: (If yes, please attach a copy of the decision and a detailed explanation for the discipline and a copy of the consent agreement(s) or decision & order(s) issued)

Has this license ever been revoked, suspended, limited, surrendered, restricted, placed on probation, encumbered in any way or is it currently under investigation? Yes No

Date of last inspection: _____

Has any inspection of the applicant resulted in deficiency ratings? Yes No

Signature: _____

Title: _____

State completing this form: _____

Date: _____

(SEAL)