

# OREGON BOARD OF PHARMACY

**TO:** All Correctional Facility Licensees

**FROM:** Licensing Representatives

**DATE:** January 7, 2009

**RE:** Required Supplemental Information

Oregon Board of Pharmacy

License Number

---

Institution Name

---

Contact Name

---

Physical Location address

---

Contact Title

---

---

Contact Phone

---

Location Phone Number

---

Contact Email:

---

Mailing Address

---

Federal Tax ID #

---

---

Please list the name of your registered nurse or nurse practitioner and consultant pharmacist.

Registered Nurse or  
Nurse Practitioner

---

RN/NP License #

---

Consultant Pharmacist

---

Consultant Oregon License #

---

FOR INTERNAL USE ONLY	
RECEIVED:	DATE ENTERED: _____