

OREGON BOARD OF PHARMACY

TO: All County Health Clinic Licensees

FROM: Licensing Representatives

DATE: January 7, 2009

RE: Required Supplemental Information

Oregon Board of Pharmacy
License Number

Clinic 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 clinic administrator, health officer and registered nurse.

Clinic Administrator:

Health Officer

Registered Nurse:

FOR INTERNAL USE ONLY

RECEIVED:

DATE ENTERED: _____