

# OREGON BOARD OF PHARMACY

**TO:** All Family Planning Clinic Licensees

**FROM:** Licensing Representatives

**DATE:** January 7, 2009

**RE:** **Required Supplemental Information**

Oregon Board of Pharmacy  
License Number

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Clinic Name

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Contact Name 

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Physical Location address

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Contact Title 

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Contact Phone 

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Location Phone Number

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Contact Email: 

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Mailing Address

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Federal Tax ID # 

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Please list the name of your Clinic Administrator, Consultant Pharmacist  
& Registered Nurse or Nurse Practitioner.

Clinic Administrator:

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Consultant Pharmacist:

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Consultant License Number

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Registered Nurse or Nurse Practitioner

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For Internal Use Only	
RECEIVED:	ENTERED BY: _____