

OREGON BOARD OF PHARMACY

TO: All County Health Clinic Registrants

FROM: Oregon Board of Pharmacy

DATE: January 9, 2016

RE: Required Supplemental Information

Oregon Board of
License Number: _____

Clinic Name: _____

Physical Location Address: _____

Location Phone Number: _____

Mailing Address: _____

Please list the name of your clinic administrator, health officer and
registered nurse.

Clinic Administrator: _____

Health Officer: (Physician) _____

Registered Nurse: _____

Contact Name: _____

Contact Title: _____

Contact Phone: _____

Contact Email: _____

Federal Tax ID # _____

***ALL FIELDS MUST
BE COMPLETED FOR PROCESSING.***