Florida HEALTH

PHARMACY MANAGER'S/CONSULTANT PHARMACIST'S STATEMENT OF COMPLIANCE

Name of Establishment _____ PERMIT NUMBER _____

Address _____ DEA NUMBER _____

City _____ County _____ State _____ Zip _____

STATEMENT OF COMPLIANCE

I hereby certify that I have made a thorough inspection of the above-referenced pharmacy, of which I am the Prescription Department Manager/Consultant Pharmacist, and the deficiencies listed on the notice have been corrected.

I hereby certify that any attached documentation is true and correct to the best of my knowledge and is provided to the Florida Department of Health to demonstrate compliance with the requirements of the Notice of Deficiencies.

Pharmacy Manager/Consultant _____ Date _____

STATE OF FLORIDA
COUNTY OF _____

Before me, personally appeared _____ whose identity is known to me

by _____ (type of identification) and who, acknowledges that his/her signature

appears above.

Sworn to or affirmed before me this _____ day of _____ , 20 _____ .

_____ _____
Notary Public - State of Florida Type or Print Name

My Commission Expires _____

Please mail to

Inspection Office

Mailing Address

ID _____

_____ _____ _____
Institutional Representative Date Investigator/Sr. Pharmacist Signature

Complete Save