BOARD OF PHARMACY
SUPERVISOR'S QUARTERLY REPORT

Please print or write legibly.

Respondent's Name:			
Respondent's License Number:		Case Number:	
Address:	_____ _____ City State Zip		
Telephone Number			
Monitor:			
Address:	_____ _____ _____ _____ City State Zip		
Telephone Number			
Quarter (3 months)	From: To:		

Name, address, license number and phone number for each pharmacy intern, pharmacy technician, relief pharmacist, and prescription department manager working with the Respondent

A brief description of Respondent's duties and responsibilities

Status of conduct and progress

Respondent's usual working schedule:

_____

_____

_____

Detail any problems which may have arisen with licensee

_____

_____

_____

_____

_____

Signature: _____ Date: _____

STATE OF_____
COUNTY OF _____

Before me, personally appeared _____, whose identity is
Please print
known to me by _____(type of identification) and who

acknowledges that his/her signature appears above.

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

_____
Notary Public

_____ _____

Type or Print Name My Commission Expires

Mailing Address: Department of Health, Compliance Management Unit
4052 Bald Cypress Way, Bin C76 • Tallahassee, FL 32399
Fax: (850) 488-0796

BOARD OF PHARMACY
RESPONDENT'S QUARTERLY REPORT

Please print or write legibly.

Respondent's Name:			
Respondent's License Number:		Case Number:	
Address:	_____ _____ City State Zip		
Telephone Number			
Monitor:			
Address:	_____ _____ _____ _____ City State Zip		
Telephone Number			
Quarter (3 months)	From: To:		

Brief statement of why Respondent is on probation:

_____

_____

_____

_____

Description of current practice and location:

_____

_____

_____

_____

Brief statement of compliance with probationary terms:

_____

_____

_____

_____

Brief statement of licensee's relationship with supervising person:

_____

_____

_____

Detail any problems which may have arisen with licensee

_____

_____

_____

_____

_____

Signature: _____ Date: _____

STATE OF_____
COUNTY OF _____

Before me, personally appeared _____, whose identity is
Please print
known to me by _____(type of identification) and who

acknowledges that his/her signature appears above.

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

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BOARD OF PHARMACY
RESPONDENT'S QUARTERLY REPORT

Please print or write legibly.

Respondent's Name:			
Respondent's License Number:		Case Number:	
Address:	_____ _____ City State Zip		
Telephone Number			
Reporting Period	From: To:		

Please initial

_____ According to the terms of my final order, I am required to notify the Department of Health of my employment status as a Pharmacist. I am not employed as a Pharmacist.

Signature: _____ Date: _____

STATE OF_____
COUNTY OF _____

Before me, personally appeared _____, whose identity is
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known to me by _____(type of identification) and who

acknowledges that his/her signature appears above.

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

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Notary Public

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