

Wisconsin Department of Safety & Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935

FAX #: (608) 261-7083
Phone #: (608) 266-2112

1400 E. Washington Avenue
Madison, WI 53703

E-Mail: web@dsps.wi.gov
Website: http://dsps.wi.gov

PHARMACY EXAMINING BOARD

PHARMACY VARIANCE REPORT

DELIVERY

COMPLETED REPORTS MUST BE SUBMITTED TO THE BOARD ON OR BEFORE JANUARY 31 AND JULY 31 OF EACH YEAR AFTER A DELIVERY OR TECH-CHECK-TECH VARIANCE IS GRANTED.

DBA NAME OF PHARMACY: (This must be the name on the pharmacy label.)

WI LICENSE NUMBER:

DATE VARIANCE GRANTED:

TELEPHONE:

EMAIL:

CONTACT PERSON:

PHARMACY ADDRESS (pharmacy location to which the variance applies): number, street, city, zip code

DELIVERY VARIANCE REPORT

TIME PERIOD

January 1-June 30

July 1-December 31

TOTAL NUMBER OF PRESCRIPTIONS DISPENSED: _____

TOTAL NUMBER OF PRESCRIPTIONS DELIVERED PURSUANT TO THE VARIANCE: _____

TOTAL NUMBER OF CONSULTATIONS BY PHARMACIST FOR PRESCRIPTIONS DELIVERED PURSUANT TO THE VARIANCE: _____ IN PERSON _____ PHONE _____ OTHER _____

OF THE PRESCRIPTIONS DELIVERED PURSUANT TO THE VARIANCE, INDICATE THE NUMBER OF:

Prescriptions Not Picked Up By Patient	Prescriptions Returned To Pharmacy	Prescriptions Destroyed	If Destroyed, how:

OTHER REPORTING REQUIREMENTS: Yes No If yes, attach additional sheets.

ADDITIONAL INFORMATION/COMMENTS:

Wisconsin Department of Safety & Professional Services

I/We declare that the foregoing statements are true and correct to the best of my/our knowledge and belief; the variance applied for is to cover only the pharmacy indicated above and at the location(s) specified; and that I/we will comply with the provisions of the Wisconsin Statutes and the Rules of the Pharmacy Examining Board.

Reporter Signature

Title

Date

Printed Name of person signing above

#3003 (7/12)
Ch. 450, Stats.

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