

Pharmacy Examining Board

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Madison, WI 53703

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Website: <http://dsps.wi.gov>

PHARMACIST TO PHARMACY TECHNICIAN RATIO PILOT PROGRAM APPLICATION

DBA NAME OF PHARMACY: (This must be the name on the pharmacy license.)	PHARMACY TELEPHONE:	PHARMACY WI LICENSE NUMBER:
PHARMACY ADDRESS (pharmacy location to which the waiver applies):		number, street, city, zip code
MANAGING PHARMACIST:	EMAIL:	

Wisconsin Department of Safety and Professional Services

I attest that I have read, understand, and will comply with all requirements of pharmacist to pharmacy technician ratio pilot program requirements; the application covers only the pharmacy indicated above and at the location specified; and that I will comply with the provisions of the Wisconsin Statutes and the Rules of the Pharmacy Examining Board.

Managing Pharmacist Signature

WI License Number

Date

Printed Name of person signing above