Pharmacy Examining Board

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PHARMACIST TO PHARMACY TECHNICIAN RATIO PILOT PROGRAM REPORT

COMPLETED REPORTS MUST BE SUBMITTED TO THE BOARD ON OR BEFORE JULY 31 OF EACH YEAR. PLEASE NOTE: ADDITIONAL DETAILS MAY BE REQUESTED BY THE BOARD ON A CASE BY CASE BASIS.

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:					

FOR TIME PERIOD D //// / TO // // Month Day Year

Month	Total Pharmacy Technician Hours Worked	Total Pharmacist Hours Worked	Pharmacist to Pharmacy Technician Hours Ratio
Example	800	160	5:1
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

I declare that the foregoing statements and attached corresponding documents are true and correct to the best of my/our knowledge and belief.

Managing Pharmacist Signature

WI License Number

Date

Printed Name of person signing above