Virginia Department of
Health Professions
Board of Pharmacy

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AFFIDAVIT FOR LIMITED-USE PHARMACY TECHNICIAN

To be completed by Free Clinic Director or Pharmacist-In-Charge

Applicant Name: ______________________________

Free Clinic Name: ______________________________

I certify that the above named applicant for a limited-use pharmacy permit is currently working or planning to work, or currently volunteering or planning to volunteer as a pharmacy technician in the free clinic also noted above, and to the best of my knowledge, is not performing pharmacy technician duties in a setting other than a free clinic.

Signature of Free Clinic Director	Print Name Legibly	Date

or

Signature of Pharmacist-In-Charge	Print Name Legibly	Date

Please check the correct box below:

Reimbursement of an examination fee incurred should be made payable to

- ☐ the applicant named above
- ☐ the free clinic named above