VIRGINIA
Department of Health Professions

PHARMACIST / PHARMACY TECHNICIAN SELF REPORT

This report covers only the current quarter:

☐ **Jan – Mar** of **20**___ or ☐ **Apr – Jun** of **20**___ or ☐ **Jul – Sep** of **20**___ or ☐ **Oct – Dec** of **20**___

Must be received from 5 days *before* until 5 days *after* the end date of current quarter: e.g.: *if due 3/31, must receive 3/26 to 4/5.*

NAME: ______________________________

ADDRESS OF RECORD: ______________________________

CITY / STATE / ZIP: ______________________________

Note: Any change in address of record must be filed with the Board of Pharmacy in writing. You may NOT do so on this form.

PHONE (HOME): ______________ **PHONE (CELL)** ______________

PHONE (WORK): ______________ **EMAIL ADDRESS** ______________

CURRENT EMPLOYMENT: **(List primary employer here, and all additional current employment on a separate, attached, sheet)**

FACILITY: ______________________________

ADDRESS: ______________________________

CITY / STATE / ZIP: ______________________________

PHONE: ______________________________

NAME OF SUPERVISOR: ______________________________

DATE HIRED / EMPLOYED: ______________ **DATE TERMINATED / RESIGNED (if applicable)** [1]**:** ______________

Is this a position requiring licensure as a pharmacist or pharmacy technician? ☐ **Yes** ☐ **No** [2]

MISCELLANEOUS:

ANY ARRESTS?	☐ Yes	☐ No	Explain below or attach explanation
ANY CONVICTIONS?	☐ Yes	☐ No	Explain below, and provide copy
UPCOMING COURT DATES:	☐ Yes	☐ No	Explain below or attach explanation
ANY ACTION BY ANOTHER STATE LICENSING BOARD?	☐ Yes	☐ No	Explain below or attach explanation, and provide copy

LICENSEE SIGNATURE: ______________________________ **DATE:** ______________

EXPLANATIONS, CONCERNS, AND COMMENTS:

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1. If you were terminated or resigned, please explain the circumstance above or attach an explanation as to the reason.
2. If you checked "no", please list explain above, or attach the job responsibilities and duties.

Virginia Board of Pharmacy
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