Secretary of State
Office of Professional Regulation

PHARMACY
Statement(s) of Pharmacist in Charge

Name of Drug Outlet or Pharmacy			
Pharmacy Address City, State, Zip			
Pharmacy License #		Email Address	
Print your name as a **Pharmacist Manager** Attesting to the statements below			

1. **I certify that the applicant has the ability to provide the board a record of a prescription drug order dispensed by the applicant to a resident of this state no later than 72 hours after a request for the record by the board.**
2. **I certify that I am the pharmacist manager and that I have read and understand the Vermont laws and rules relating to a non-resident pharmacy.**
3. **I certify that during its regular hours of operation, but not fewer than six days per week, for a minimum of 40 hours per week, a toll- free telephone service is provided to facilitate communication between patients in this state and a pharmacist at the pharmacy who has access to patients records. The toll-free number must be disclosed on the label affixed to each container of drugs dispensed to residents of the state.**

Statement of Applicant

I certify, under the pains and penalties of perjury, that all information I have provided in this application is true and accurate. I understand that furnishing false information may constitute unprofessional conduct and result in the denial of my application or further disciplinary action. The maximum penalty for perjury is fifteen years in prison and/or a $10,000 fine. (13 V.S.A. §2901)
Signature of Pharmacist Manager Date

Affix Prescription Label below or provide separately.