Affidavit of Assurance of Pharmacist-in-Charge Compliance

State of _____ , County of _____

I, _____ , being duly sworn upon by oath state:

1. I am aware that as an Arkansas Pharmacist-in-Charge I am required to work half the number of hours that the facility is open with a maximum of 20 hours per week.

2. Pharmacist _____ License # _____
   Pharmacist's Name Here — Pharmacist License Number Here

3. Facility _____ License # _____
   Facility's Name Here — Facility's Arkansas License Number Here

Check one of the following:

☐ Routinely works a minimum of 20 hours per week at this Arkansas licensed facility.
☐ Does not routinely work a minimum of 20 hours per week at this Arkansas licensed facility.
☐ Is no longer the Arkansas Pharmacist-in-Charge at this Arkansas licensed facility. Explain:
☐ Other. Explain:

_____
Printed Name of Pharmacist — Signature of Pharmacist

Subscribed and sworn to before me this _____ day of _____ , 20 _____

_____
Notary Public Signature

My Commission Expires:

Print, Type, or Stamp Name of Notary

Return to:
Arkansas State Board of Pharmacy
322 South Main Street, Suite 600
Little Rock, AR 72201
Telephone: 501-682-0190