

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

Check one of the following:

<input type="checkbox"/> Routinely works a minimum of 20 hours per week in the Arkansas licensed facility.
<input type="checkbox"/> Has not routinely worked a minimum of 20 hours per week in the Arkansas licensed facility.
<input type="checkbox"/> Is the Arkansas Pharmacist-in-Charge, but the facility currently does not ship products into Arkansas. Explain:
<input type="checkbox"/> 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:
_____ <small>Print, Type, or Stamp Name of Notary</small>

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