MINNESOTA BOARD OF PHARMACY
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PHARMACIST'S/TECHNICIAN'S HOME ADDRESS AND/OR EMPLOYMENT CHANGE

Name: ______________________ Regis. or Lic. Number: __________

Designated Mailing Address: ______________________________

____

Designated Phone Number: __________ Designated Fax Number: __________

Designated E-Mail: __________

Note: The information you provide us under "Designated" categories on this form is considered public information.

PREVIOUS EMPLOYER

Name and Address of This Employer: ______________________________

____

Date you Left Employment: __________ Were you Pharmacist-in-charge? Yes ☐ No ☐

PRIMARY EMPLOYER (***Check the box that indicates what type of business this employer has)***

- ☐ Retail
- ☐ Long Term Care
- ☐ Teaching/Government
- ☐ Other, Non-Pharmacy Related
- ☐ Hospital
- ☐ Nuclear
- ☐ Relief
- ☐ Retired
- ☐ Parenteral/Enteral-Home Health Care
- ☐ Manufacturer/Wholesaler
- ☐ Other, Pharmacy Related
- ☐ Unemployed

Name and Address of This Employer: ______________________________

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Starting Date of Employment: __________ License Number of Employer: __________

Full Time ☐ Part Time ☐ Will you be Pharmacist-in charge? Yes ☐ No ☐

SECONDARY EMPLOYER (***Check the box that indicates what type of business this employer has)***

- ☐ Retail
- ☐ Long Term Care
- ☐ Teaching/Government
- ☐ Other, Non-Pharmacy Related
- ☐ Hospital
- ☐ Nuclear
- ☐ Relief
- ☐ Retired
- ☐ Parenteral/Enteral-Home Health Care
- ☐ Manufacturer/Wholesaler
- ☐ Other, Pharmacy Related
- ☐ Unemployed

Name and Address of This Employer: ______________________________

____

Starting Date of Employment: __________ License Number of Employer: __________

Full Time ☐ Part Time ☐ Will you be Pharmacist-in charge? Yes ☐ No ☐