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Idaho State Board of Pharmacy

1199 W Shoreline Lane Ste 303 Boise, Idaho 83702-9103 http://bop.idaho.gov
P.O. Box 83720 Boise, Idaho 83720-0067 208.334.2356 208.334.3536 fax

TERMINATION OF EMPLOYMENT

Use this form to report employee terminations to the Board

****PRINT using BLOCK letters or type – illegible applications will not be processed****

EMPLOYEE INFORMATION

NAME_____
FIRST MIDDLE LAST

DATE OF BIRTH: _____ REGISTRATION/LICENSE # _____

EMPLOYER INFORMATION

Last Date of Employment:_____

PHARMACY NAME_____

PHONE NUMBER _____ PHARMACY LICENSE NUMBER_____

Reason for termination:

_____

_____

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_____

PRINTED NAME OF PHARMACIST- IN-CHARGE_____

I hereby certify that the above statements are true and correct.

_____
SIGNATURE OF PHARMACIST IN CHARGE DATE