Idaho State Board of Pharmacy

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Pharmacy Student Technician Supervised Program Information

To be completed by Pharmacy Student Technician:

Name: _____ Contact Ph#: _____

Email Address: _____

Signature of Applicant: _____ Date: _____

To Be Completed by Program Official:

Program/School Name: _____

Idaho Pharmacy Name: _____

Idaho Pharmacy License #: _____ or Address: _____

City: _____ Zip: _____

Officials' Printed Name: _____ Contract Ph#: _____

Email Address: _____

Signature of Official: _____ Date: _____