

**NON-RESIDENT PHARMACY  
CERTIFICATE OF PROFESSIONAL RESPONSIBILITY**

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**NOTICE:** The following is to be completed by the licensed pharmacist charged with management of the pharmacy.

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**Type or print:**

**PHARMACY:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

MN License #: \_\_\_\_\_

**PREVIOUS PHARMACIST IN CHARGE:**

Name: \_\_\_\_\_

License #: \_\_\_\_\_

**NEW PHARMACIST IN CHARGE:**

Name: \_\_\_\_\_

License #: \_\_\_\_\_

**DATE THE NEW PIC POSITION BEGAN:**

Date: \_\_\_\_\_

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SIGNATURE OF CURRENT PHARMACIST-IN-CHARGE

Return to:  
MINNESOTA BOARD OF PHARMACY  
2829 UNIVERSITY AVENUE SE, SUITE 530  
MINNEAPOLIS, MN 55414-3251

Fax: (612) 617-2262  
Email: [pharmacy.board@state.mn.us](mailto:pharmacy.board@state.mn.us)