MINNESOTA
BOARD OF PHARMACY

Verification Request for License/Registration

Requester Name _____ Date _____

Email Address _____

Phone Number _____

License/Registration Type *(Select one, unless there are multiple licenses/registrations for the individual/facility)*

- ☐ Controlled Substance Researcher
- ☐ Intern
- ☐ Pharmacist
- ☐ Technician
- ☐ Manufacturer
- ☐ Medical Gas Distributer
- ☐ Pharmacy
- ☐ Wholesaler

MN License/Registration Number(s) _____

Name on License/Registration _____

City/State/Zip _____

☐ Include copies of disciplinary documentation

Send Verification Results to: ***(select one method)***

Email *(preferred method)* _____

Mail

Name _____

Address _____

City/State/Zip _____

Download and submit completed form to the MN Board of Pharmacy by mail, fax, or e-mail.

Requests will be *processed* within 3 business days of receipt.

For Office Use Only
Date
Initials

2/2022

Minnesota Board of Pharmacy
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