

PHARMACIST LEAVING PIC POSITION CERTIFICATE OF PROFESSIONAL RESPONSIBILITY

NOTICE: The following is to be completed by the licensed pharmacist that will no longer be charged with management of the pharmacy.

Type or print:

I, _____, the undersigned, hereby certify that:

I reside at _____.
ADDRESS CITY STATE ZIP

I am a licensed pharmacist in the state of _____ assigned license # _____.

On _____ I left the position of pharmacist-in-charge of the pharmacy
DISCONTINUATION DATE

known as _____,
NAME OF PHARMACY LICENSE #

at _____,
ADDRESS CITY STATE ZIP

and that I no longer assume professional responsibility for said pharmacy.

Are you still working for this pharmacy? Yes No

SIGNATURE OF PREVIOUS PHARMACIST-IN-CHARGE

DATE

Return to:

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