MARP QUARTERLY REPORT

Name: ____

License/Registration Number: ____

Current Address:

Street: ____

City, State, Zip: ____

Phone: (home)____________________________ (cell) ______________________________________

Email address: ____

Current Employment/Address

Pharmacy Name: ____

Street: ____

City, State, Zip: ____

Current Prescribed Medications: Provide the name of the drug, the number and strength of the doses prescribed, the dosage regimen and the name of the prescriber.

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Please provide any other information that may be relevant to your professional well-being:

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Signature: _______________________________________ Date: _________________________

This report is due the first week of January, April, July and October. It should be sent to:

Mississippi Board of Pharmacy
6360 I-55 N., Suite 400
Jackson, MS 39211
compliance@mbp.state.ms.us
Fax: (601) 899-8891