

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.

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

Signature: _____ Date: _____

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

Mississippi Board of Pharmacy
6311 Ridgewood Road
Suite E 401
Jackson, MS 39211
compliance@mbp.state.ms.us
Fax: (601) 899-8891