Pharmacist Change of Employment Form

Please return this form to:
South Carolina Board of Pharmacy
P O Box 11927
Columbia, SC 29211 1927
Or fax to 803-896-4596

This form must be completed and returned to the Board of Pharmacy when a pharmacist changes employment.

Personal information provided in this application may be subject to public scrutiny or release under the S.C. Freedom of Information Act or other provisions of federal and state law.

(Please print information)

Pharmacist Information

Pharmacist Name: ___________________________________________________________

South Carolina License Number _______________ SSN# __________________________

New Employer Information

Check if Applicable [ ] Pharmacist –in-Charge [ ] Staff Pharmacist [ ] Permit Holder

Name of Pharmacy_________________________________________ Pharmacy Permit#:_______________________

Address of Pharmacy: _____________________________________________ Start Date: _______________________

City ____________________________ State___________ Zip________ Phone (     ) _____________

Previous Employer Information:

Check if Applicable [ ] Pharmacist –in-Charge [ ] Staff Pharmacist [ ] Permit Holder

Name of Pharmacy________________________________________  Pharmacy Permit#:___________________

Address of Pharmacy: ______________________________ Start Date: _____________ End Date_________________

City ____________________________ State___________ Zip________ Phone (     ) ____________

Additional Places of Employment:

Name of Pharmacy: ___________________________________________ Pharmacy Permit #:___________________

Address of Pharmacy: ___________________________________________ Start Date: _________________ End Date: _ ___________

City ___________________________________ State _______ Zip ______________ Phone (        ) ______________

Name of Pharmacy: ____________________________________________ Pharmacy Permit #:___________________

Address of Pharmacy: __________________________________________ Start Date: _____________________

City ______________________________ State _______ Zip ______________ Phone (        )___________________