

# OREGON BOARD OF PHARMACY

**TO:** All Correctional Facility Registrants  
**FROM:** Oregon Board of Pharmacy  
**DATE:** January 9, 2016  
**RE:** Required Supplemental Information

Oregon Board of Pharmacy

License Number \_\_\_\_\_

DEA Number \_\_\_\_\_

Institution Name \_\_\_\_\_

Physical Location Address \_\_\_\_\_  
\_\_\_\_\_

Location Phone Number \_\_\_\_\_

Mailing Address \_\_\_\_\_  
\_\_\_\_\_

Contact Name \_\_\_\_\_

Contact Title \_\_\_\_\_

Contact Phone \_\_\_\_\_

Contact Email: \_\_\_\_\_

Federal Tax ID # \_\_\_\_\_

**ALL FIELDS MUST BE COMPLETE  
FOR PROCESSING**

Please list the name of your registered nurse or nurse practitioner and consultant pharmacist.

Registered Nurse or  
Nurse Practitioner \_\_\_\_\_

Consultant Pharmacist \_\_\_\_\_

Consultant Oregon License # \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Address \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Address \_\_\_\_\_

Please list the name and address of all pharmacies you receive drugs from. A list may be attached for additional entries.