Idaho State Board of Pharmacy

3380 Americana Terrace #320 PO Box 83720 Boise ID 83720-0067
208/334-2356 208/334-3536 Fax

TERMINATION OF EMPLOYMENT

Use this form to report employee terminations to the Board

****PRINT using BLOCK letters or type – illegible applications will not be processed****

EMPLOYEE INFORMATION

NAME_____
FIRST MIDDLE LAST

DATE OF BIRTH: _____ SS#:_____

ADDRESS_____
NUMBER STREET

CITY, STATE, & ZIP_____

PHONE ( ) _____-_____ REGISTRATION/LICENSE # _____

EMPLOYER INFORMATION

Last Date of Employment:_____

PHARMACY NAME_____

PHONE NUMBER ( ) _____-_____ PHARMACY LICENSE NUMBER_____

Reason for termination: _____

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PRINTED NAME OF PHARMACIST- IN-CHARGE_____

I hereby certify that the above statements are true and correct.

_____
SIGNATURE OF PHARMACIST IN CHARGE DATE