NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Parkway, Suite 206 - Reno, NV 89521 - (775) 850-1440

Pharmacy/ Pharmacist Notification of Self-Administered Hormonal Contraceptives Dispensing

Rev (06/30/2022)

Email the completed form to pharmacy@pharmacy.nv.gov

Section 1: Pharmacy Information

Pharmacy Manager Name: _____ Pharmacy Manager License #: _____

Name of Pharmacy:_____ Pharmacy License #: _____

Pharmacy Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Section 1: Pharmacist Information

Name of Pharmacist: _____ License #: _____

Name of Pharmacist: _____ License #: _____

Name of Pharmacist: _____ License #: _____

Name of Pharmacist: _____ License #: _____

Name of Pharmacist: _____ License #: _____

Name of Pharmacist: _____ License #: _____

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Name of Pharmacist: _____ License #: _____

Name of Pharmacist: _____ License #: _____

Name of Pharmacist: _____ License #: _____

Name of Pharmacist: _____ License #: _____

Name of Pharmacist: _____ License #: _____

Name of Pharmacist: _____ License #: _____

Name of Pharmacist: _____ License #: _____

☐ I certify that that above named pharmacist(s) meet the requirements pursuant to NRS 639.28077, NRS 639.28078 and LCB File # R036-21 to dispense self-administered hormonal contraceptives.

☐ I certify under penalty of perjury that the information contained on this form is accurate, true and complete in all material respects. I understand that making any false representation in this form is a crime under NRS 639.281. I understand that, pursuant to NRS 239.010, this form and any portion thereof is a public record unless otherwise declared confidential by law, and may be considered by the Nevada State Board of Pharmacy at a public meeting pursuant to NRS 241.020.

_____

Print Name (First, Last) of the Individual Pharmacist or Managing Pharmacist completing this form

_____ _____

Original Signature of Individual Pharmacist or Managing Pharmacist completing this form, no copies or stamps accepted

Date

Board Use Only	Date Received: _____