

**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 (04/18/2023)

Email the completed form to [teambc@pharmacy.nv.gov](mailto:teambc@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 #: \_\_\_\_\_  
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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

<b>Board Use Only</b>	Date Received: _____
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