PHYSICIAN'S ASSISTANT (PA)
INFORMATION AND CHECKLIST - DISPENSE

This application cannot be returned by fax or email.
We must have an original signature(s) and fee to process.

Download application and mail to the address on the top of the application with the required $300.00 fee. The fee is payable by money order or cashier's check only, we do not accept personal or business checks, cash or credit cards. If the application is received with a personal check or cash, it will be returned and will delay the processing of your application.

Fee is made payable to: **Nevada State Board of Pharmacy**

Before calling with questions, please read all information carefully.

You must are required to have either a prescribing registration or controlled substance registration with the pharmacy board to obtain a dispensing license.

Upon receipt of the completed application and fee, you will be provided a Nevada law book for study for the dispensing examination and instructions on scheduling the required law exam.

You are not authorized to dispense until the dispensing registration has been issued. This requires passing the dispensing exam.

If your dispensing address changes, you will be required to submit a new application before moving and pay the $300.00 fee. The new location will require an inspection. You will not be required to retake the dispensing exam.

All registrations expired October 31, of the even numbered years, no matter when the license is issued. If you have any questions, please feel free to contact the Reno office at 775/850-1440..

NEVADA STATE BOARD OF PHARMACY
985 Damonte Ranch Pkwy Ste 206 – Reno, NV 89521

APPLICATION FOR PHYSICIAN'S ASSISTANT • DISPENSE

You must have current pharmacy board registration to submit this application.

REGISTRATION FEE: $300.00 (non-refundable **money order or cashier's check only, no cash)**

First:_____ Middle:_____ Last:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____ Telephone:_____

SS# or ITIN:_____ Date of Birth:_____ E-mail address: _____

Medical or Osteopathic License #:_____ Pharmacy Board #: _____

PRACTICING LOCATION

Practice Name (if any): _____

Physical Address:_____ Suite #:_____

City:_____ State:_____ Zip Code: _____

Telephone:_____ Fax: _____

SUPERVISING PHYSICIAN – Please Print

First:_____ Middle:_____ Last:_____

Physical Address:_____ Suite #: _____

City:_____ State:_____ Zip Code: _____

	Yes	No
Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or Physical condition that would impair your ability to perform the essential functions of your license?	☐	☐
1. Been charged, arrested or convicted of a felony or misdemeanor in any state?	☐	☐
2. Been the subject of an administrative action whether completed or pending in any state?	☐	☐
3. Had your license subjected to any discipline for violation of pharmacy or drug laws in any state?	☐	☐

If you marked **YES** to any of the numbered questions (**1-3**) above, include the following information & **provide documentation**:

	State	Date:	Case #:	County	Court
Board Administrative Action:		/ /			
Criminal Action:		/ /			

I hereby certify, under penalty of perjury, that the information furnished on this application is true, accurate and correct.

_____ _____
Original Signature of PA, no copies or stamps accepted Date

_____ _____
Original Signature of Supervising Physician, no copies or stamps accepted Date

Board Use Only
Received_____ Amount_____ Entity: _____