



Washington State Department of

Health

Pharmacy Quality Assurance
Commission Credentialing
PO Box 47877
Olympia, WA 98504-7877
360-236-4700

Verification of Current Active Pharmacy Practice

_____ has been employed as a
(Print applicant name clearly)

Pharmacy Technician

Pharmacist

Other, please explain _____

by this organization from _____ until _____
(mm/dd/yyyy) (mm/dd/yyyy)

Pharmacy/Employer Information:

Name _____ Phone (enter 10 digit #) _____

Pharmacy State License Number (if applicable) _____

Email Address _____

Street Address _____

City _____ State _____ Zip Code _____

Person Completing Form:

Name _____ Phone (enter 10 digit #) _____

Email Address _____

Credential type and number (if applicable) _____

Title _____

Signature _____ Date _____