



**State of Florida
Department of Health
Investigative Services**

4052 Bald Cypress Way, BIN # C70 • Tallahassee, FL 32399-3270



WWW.DOH.STATE.FL.US

PHARMACY CORPORATE STATEMENT OF COMPLIANCE

Name of Establishment _____ License Number _____
 Address _____ DEA Number _____
 City _____ County _____ State _____ Zip _____
 Date of Inspection _____

STATEMENT OF COMPLIANCE

I certify that I am an owner or officer of the corporation of the above named pharmacy, that I have reviewed the Notice of Deficiencies and have taken the steps necessary to assure their correction.

Owner/Officer of Corporation _____ Date _____

STATE OF FLORIDA
 COUNTY OF _____

Before me, personally appeared _____ whose identity is known to me
 by _____ (type of identification) and who, acknowledges that his/her signature
 appears above.

Sworn to or affirmed before me this _____ day of _____, 20 ____ .

 Notary Public – State of Florida

 Type or Print Name

My Commission Expires _____

Please mail to _____

Mailing Address _____

City _____ State _____ Zip _____