STATE OF FLORIDA
DEPARTMENT OF HEALTH
INVESTIGATIVE SERVICES
4052 Bald Cypress Way, BIN # C70 • Tallahassee, FL 32399-3270

WWW.DOH.STATE.FL.US

PHARMACY MANAGER'S/CONSULTANT PHARMACIST'S STATEMENT OF COMPLIANCE

Name of Establishment ______________________________ License Number ________________________

Address ____ DEA Number __________________________

City ______________________ County _______________ State _________________ Zip ____________

STATEMENT OF COMPLIANCE

I hereby certify that I have made a thorough inspection of the above-referenced pharmacy, of which I am the Prescription Department Manager/Consultant Pharmacist, and the deficiencies listed on the notice have been corrected.

I hereby certify that any attached documentation is true and correct to the best of my knowledge and is provided to the Florida Department of Health to demonstrate compliance with the requirements of the Notice of Deficiencies.

Pharmacy Manager/Consultant ____ 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________________