



State of Utah
 Department of Commerce
 Division of Occupational and Professional Licensing

GARY R. HERBERT
 Governor

FRANCINE A. GIANI
 Executive Director

MARK B. STEINAGEL
 Division Director

**Notification Form for Pharmacy Technicians
 for On-the-Job Pharmacies**

Training Start Date: ___/___/___ Anticipated Date of Completion: ___/___/___

Last Name of Technician-in-Training: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) ____-____ Email: _____

Gender: Male Female Date of Birth: ___/___/___

Social Security Number: ____-____-____

I certify under penalty of perjury that I am a United States citizen or a qualified alien who is lawfully able to work in the United States.

Signature of Applicant: _____ Date: ___/___/___

Name of Pharmacy: _____

Street Address of Pharmacy: _____

City, State and Zip of Pharmacy: _____

Phone Number of Pharmacy: (____) ____-____

Pharmacy's Utah License Number: _____

Teaching Pharmacist(s): _____

Name: _____ License Number: _____

Name: _____ License Number: _____

Approved Program: _____

Comments: _____

This form must be submitted PRIOR to beginning the training of the pharmacy technician. Training done in a non-approved program will not be given credit, and training will have to be repeated in an approved program. It is the responsibility of the pharmacist or program director to ensure that the pharmacy technician is aware of the policies and procedures of the training program. By signing this form, you attest that you have discussed the training program and have a full understanding of what is expected.

Signature of Pharmacist: _____ Date Signed: ___/___/___

Signature of Technician: _____ Date Signed: ___/___/___

Send To: **Utah Board of Pharmacy
 PO Box 146741
 Salt Lake City, Utah 84114-6741**

