



Virginia Department of  
**Health Professions**  
Board of Pharmacy

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## REGISTRATION FOR A PHARMACY TO BE A COLLECTION SITE FOR DONATED DRUGS

**Applicant—Please provide the information requested below. (Print or Type) Use full name not initials**

Name of Pharmacy	Area Code and Telephone Number	
Street Address	Area Code and Fax Number	
City	State	Zip Code
Email address		
If a current pharmacy permit is held, indicate the permit number <b>0201-</b>		
Expected start date for collection of donated items		