

APPLICATION FOR THE MISSISSIPPI STATE BOARD OF PHARMACY

Check one: (See attached map)

____ Old Congressional Dist 1 ____ Old Congressional Dist 2 ____ Old Congressional Dist 3
____ Old Congressional Dist 4 ____ Old Congressional Dist 5
____ At-Large Retail Pharmacy ____ At-Large Institutional Pharmacy

(Type all information)

FULL NAME: _____ PHONE #: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

AGE: _____ DATE OF BIRTH: _____ PLACE OF BIRTH: _____

MS RESIDENT: YES _____ (for _____ years) NO _____ U.S. CITIZEN: YES _____ NO _____

GRADUATE OF: _____ DEGREE: _____ DATE RECEIVED: _____

LIST 5 YEARS OF PHARMACY EMPLOYMENT EXPERIENCE:

(Specify full-time or part-time employment, pharmacy name, city and dates employed)

_____ from _____ to _____
_____ from _____ to _____
_____ from _____ to _____
_____ from _____ to _____
_____ from _____ to _____

I hereby certify that the above information is true to the best of my knowledge and belief, and hereby request that my name be placed on the ballot for candidacy for the Mississippi Board of Pharmacy.

Signature: _____ Date: _____

NOTARY SEAL: State of Mississippi, _____ County

Personally appeared before me, the undersigned authority in and for the state and county aforesaid, the within Named _____ who acknowledges that he/she signed and delivered the foregoing instrument on the day and year therein stated.

Given under my hand and official seal of office this _____ day of _____, _____.

Notary Public Signature: _____

**** A CERTIFIED LETTER FROM THE SECRETARY OF STATE OR CIRCUIT CLERKS OFFICE STATING WHICH OLD CONGRESSIONAL DISTRICT YOU LIVE IN MUST BE ATTACHED IN ORDER TO BE ACCEPTED. (see attached example letter)**

BRIEF BIOGRAPHICAL SKETCH:

[illegible]

BRIEF STATEMENT OF YOUR PURPOSE FOR SEEKING THIS APPOINTMENT:

This image shows a single sheet of white paper with horizontal blue or grey ruling lines. The lines are evenly spaced and run across the width of the page. There are approximately 20 lines visible. The paper has a slight shadow on its right side, suggesting it's resting on a surface.

Signature: _____ Date: _____

MAIL THIS APPLICATION AND CERTIFICATION LETTER TO:

OR EMAIL TO:

MISSISSIPPI PHARMACISTS ASSOCIATION
PO BOX 16861
JACKSON, MS 39236

info@mspharm.org