



Pharmacist Provider Information

Name: _____

Address: _____

Telephone: _____ Fax: _____

E-Mail Address: _____

Pharmacist Provider License #: _____ NPI #: _____

Place of Employment: _____

How did you hear about the P³ Program? _____

What is your availability? (hours per week; nights/weekend/day) _____

Will you be working as an independent pharmacist or would your Pharmacy be interested in becoming part of the P3 Provider Network?

- Independent Pharmacist Pharmacy

Please list any relevant training courses or certifications you have completed.

Training/Certification	Date Completed