

Complete forms must be mailed directly from the verifying agency to the board office at info@floridaspharmacy.gov, or mailed to:

Board of Pharmacy
4052 Bald Cypress Way Bin C-04
Tallahassee, FL 32399-3258



Board of Pharmacy

Certificate of Pharmacy Education – Form A

Part I: To be completed by applicant

Applicant Name: _____
Last First Middle

Maiden Name/Surname: _____ Date of Graduation: _____
MM/DD/YYYY

Street Address: _____

City: _____ State: _____ ZIP: _____

Part II: To be completed by College of Pharmacy Dean

Name of School/College of Pharmacy: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Degree Awarded: _____ Date Degree Awarded: _____
MM/DD/YYYY

Dates of Attendance: From: _____ To: _____
MM/DD/YYYY MM/DD/YYYY

The information recorded above is true and correct according to the official records of this institution. Failure to include the school seal may result in delay in processing the applicant's application.

Dean Name: _____ Title: _____

Dean Signature: _____ Date: _____
MM/DD/YYYY

(SCHOOL SEAL)

Check to ensure that all fields have been filled in.