PHARMACISTS RECORD
(Volunteers or from other response teams)
AS OF (DATE) _____
MISSION: _____

All pharmacists at this FMS should sign in each day and complete the following table. Each pharmacists should provide copies of license/certification and valid ID for verification.
LOCATION: _____

USPHS PHARMACISTS					
NAME (Print & Signature)	**PHONE #**	**Email Address**	**NPI #**	**RPh License (#, State)**	**Immunization Certification (State)**
Pharmacy Branch Lead					
Pharmacy Branch Deputy Lead					

PHARMACISTS RECORD
(Volunteers or from other response teams)
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LOCATION: _____

PHARMACISTS								
Date	**Pharmacist Name (Print & Signature)**	**RPh Initials**	**Phone #**	**Email**	**NPI #**	**RPh License (#, State)**	**Immunization Certification (State)**	**Verified by**

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PHARMACISTS								
Date	**Pharmacist Name (Print & Signature)**	**RPh Initials**	**Phone #**	**Email**	**NPI #**	**RPh License (#, State)**	**Immunization Certification (State)**	**Verified by**