

Applicant Name: _____

9903/001	Application	\$ 30
9903/006	Regulatory fee	\$ 10



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243
PHONE: (615) 741-2718 FAX: (615) 741-2722
<http://health.state.tn.us/boards/pharmacy/>

APPLICATION FOR MEDICAL SERVICE REPRESENTATIVE

APPLICANT MUST SUBMIT THE FOLLOWING INFORMATION:

New License

Name of Applicant:

Name

Home Phone Number: (_____) _____

Street

Work Phone Number: (_____) _____

City *State* *Zip*

Social Security Number

Your employer MUST be licensed as a Manufacturer/Wholesale/Distributor (M/W/D) in Tennessee

COMPANY EMPLOYED BY:

Company Name

Telephone Number (_____) _____

Street

M/W/D License Number _____

City *State* *Zip*

Please include the \$40.00 Registration fee. Tennessee will accept personal checks made payable to the Tennessee Board of Pharmacy.

***Note: License will be mailed to the company address**