Sole Proprietorship Ownership Form

Virgin Islands Board of Pharmacy

The ORIGINAL supplemental form and all required attachments shall be mailed to:
Virgin Islands Dept of Health, Office of Professional Licensure, P.O. Box 222995, Christiansted, VI 00822

Name of Individual Owner

Physical Address

Street Address

City State Zip Code

Mailing Address

Street Address

City State Zip Code

Home Phone Number Cell Phone Number

Email Address

If you prefer the home address to remain confidential, provide an Address of Public Record below

Address of Public Record

Street Address

City State Zip Code

ATTEST: I hereby attest that the foregoing statements or those on any attachment(s) to this form are to the best of my knowledge true and correct and that they are all given of my free will. I agree that any misstatement(s) or omissions(s) as to material facts will constitute violation of and subject me to penalties set forth in the Virgin Islands Board of Pharmacy Practice Act. I agree to comply with the Virgin Islands Practice Act and Rules and Regs.

Signature of Owner Date

THIS SIGNATURE MUST BE NOTARIZED

Statement of Notary Public

Subscribed and sworn before me this _____ day of _____, 20 _____

Seal Here

Notary Public_____

My commission expires: _____