



Arkansas State Board of Pharmacy
101 East Capitol, Suite 218
Little Rock, AR 72201
501-682-0190
<http://www.arkansas.gov/asbp>

Complaint Form

Complainant Information:

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ **Work Phone:** _____

Complaint Information Regarding:

Name of Pharmacist/Technician: _____

Name of Pharmacy: _____

Pharmacy Address: _____

City, State, Zip: _____

Write a detailed statement and attach copies of records, reports, letters, etc., relative to the complaint you are filing.
Additional sheets may be attached if necessary. Please print or type if possible.

Signature of Complainant(s): _____