NORTH DAKOTA STATE BOARD OF PHARMACY CONTINUING PHARMACEUTICAL EDUCATION RECORDING FORM

Maintain your Continuing Pharmaceutical records for a minimum of 2 years

Program Date	ACPE Program No.	Program Title	Provider	CE Hours
Total				

Name (print)_____ **Signature** _____ **Lic. No.** _____ **Date** _____

DO NOT MAIL CE Certificates to the Board of Pharmacy Office unless **REQUESTED**