



Affidavit of Practice as a Pharmacist in Rural Minnesota

You are required to complete and return this ORHPC Affidavit of Practice to provide necessary documentation of your service as a pharmacist in a designated rural area.

Participant Name: _____ Phone: (____) _____

Address: _____ Cell: (____) _____

City: _____ State: _____ Zip: _____

County: _____ E-Mail: _____

_____ MN License Number: _____

Signature of Participant

Practice Site: _____ Phone: (____) _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____

To Be Completed by an Authorized Individual at the Practice Site Named Above

I certify that the above named pharmacist has worked full time (at least 30 hours per week) for at least 45 weeks per year at the designated rural site named above from ____/____/____ to ____/____/____.

Date

Date

Printed Name of Authorized Representative

Title of Authorized Representative

Signature of Authorized Representative

____/____/____
Date

Phone: (____) _____ **Email Address:** _____

Please return to: Minnesota Department of Health, Office of Rural Health and Primary Care
Attn: Loan Forgiveness Program Officer
P.O. Box 64882 St. Paul, MN 55164-0882

Or by Email: mohamed.samaha@state.mn.us **Or by Fax** (651) 201-3830

For Questions, please contact Mohamed Samaha at (651) 201-3870 or (800) 366-5424.