Arkansas Association of
Health-System Pharmacists

PHARMACY TECHNICIAN SCHOLARSHIP APPLICATION FORM

(Please Type or Print)

Name of Applicant: _____ Date:_____

Mailing Address:_____

_____

Telephone No: _____ Date of Birth: _____

E-mail Address: _____Member of AAHP _____NO _____YES

Arkansas State Board of Pharmacy Technician Registration Permit number: (for example:

PT 12345) _____

Place of employment:_____

Number of years at this place of employment:_____

If I am successful in gaining a scholarship, I give consent for my name and the award to be announced in publications and on the internet and for photographs of me taken at AAHP/ASHP and other pharmacy-related events to be used in future promotional materials.

_____ _____

Applicant Signature Date