COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
**P.O. BOX 2649**
**HARRISBURG, PA 17105**

# APPLICANT FOR TEMPORARY PROVISIONAL ENDORSEMENT LICENSE TO PRACTICE PHARMACY

**Name:** _____
**Last** **First** **Middle**

**State of Licensure as a Pharmacist and License Number:**

_____

I acknowledge that the Temporary Provisional Endorsement License will expire on January 2, 2026, and that after that date the license will expire, and I will be unable to practice pharmacy in Pennsylvania without applying for and receiving another license.

I verify that the statement made above is true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license.

Signature Date