



**DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH REGULATION AND LICENSING ADMINISTRATION
BOARD OF PHARMACY**

**PHARMACEUTICAL DETAILER
Waiver of Educational Requirements**

Part I – Applicant Information

PLEASE PRINT LEGIBLY OR TYPE ALL ENTRIES

APPLICANT'S LAST NAME	FIRST NAME	MIDDLE INITIAL	
STREET ADDRESS (DO NOT USE PO BOX)	CITY	STATE	ZIP
PHONE NUMBER	FAX NUMBER		
EMAIL ADDRESS			

I, _____, attest to the fact that I have been performing the functions of a pharmaceutical detailer as defined in Chapter 83 of Title 17 of the District of Columbia Municipal Regulations for at least thirty-two (32) hours per week for at least twelve (12) months immediate preceding March 26, 2008.

I hereby affirm that the information provided on all parts (Part I, Part IIa, and Part IIb) of this document is true and complete. I understand that the information is subject to verification and that making a materially false statement or affirmation is punishable by criminal penalties.

Signature of Applicant

Date

Subscribed and sworn to before me this _____ day of _____, 20____.
My commission expires _____.

(Notary Signature) (SEAL)



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Part II – Work Experience

INSTRUCTIONS:

List all current and former companies you have worked as a pharmaceutical detailer in the last three (3) years. Include month and year time frames of employment, including approved leave under the Family and Medical Leave Act or the District of Columbia Family Medical Leave Act. If additional space is needed, please provide on a separate sheet of paper and submit with your application.

Company/Agency Name

Street Address (DO NOT USE PO BOX)

City

State

Zip

Name of Supervisor

Phone Number

Job Title/Position

Start Date:

End Date:

Description of Practice/Experience/Duties: _____

Company/Agency Name

Street Address (DO NOT USE PO BOX)

City

State

Zip

Name of Supervisor

Phone Number

Job Title/Position

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