INspect

Indiana Board of Pharmacy /
Prescription Monitoring Program

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Pharmacy Profile Information Form

All fields are required. If any part is left blank, it will delay the processing of the Pharmacy Upload account.

NABP #:_____

Indiana License #: _____

Name:_____

Address:_____

City: _____ **State:** _____ **Zip:** _____

Telephone: _____**Fax** _____

Qualifying Pharmacist_____

Email_____

Pharmacy Type:

☐ **Type I** ☐ **Type II** ☐ **Type III**

☐ **Non-Resident**

☐ **Exempt**

Please complete this form and
email, fax or mail to:

INSPECT Program
402 West Washington Street Room W 072
Indianapolis, IN 46204
FAX: 317-232-2115
Email: inspect@pla.in.gov