Arkansas State Board of Pharmacy
322 South Main Street, Suite 600
Little Rock, AR 72201
501-682-0190 ◆ Fax 501-682-0195
www.pharmacyboard.arkansas.gov

Complaint Form

Complainant Information:

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ **Work Phone:** _____

Complaint Information Regarding:

Name of Pharmacist/Technician: _____

Name of Pharmacy: _____

Pharmacy Address: _____

City, State, Zip: _____

Write a detailed statement and attach copies of records, reports, letters, etc., relative to the complaint you are filing. The Board does not have jurisdiction over complaints involving rudeness, customer service and/or pricing/billing disputes. Additional sheets may be attached if necessary. Please print or type if possible.

Signature of Complainant(s): _____