Proud to be Tobacco Free Campaign – Registration Form

Pharmacy Name: ______________________________ *Date:* ______________________

Your Name: ____

Address: ____

City: ___________________ *State:* ________________ *Zip:* ________________________

COUNTY: ___________________ Email: ____

Phone number: ____________________________ *Fax number*: ________________________

1. My pharmacy is a(n) ❑ independent / ❑ chain / ❑ hospital facility
2. Does your store sell tobacco products? ❑ yes / ❑ no
3. Our facility ❑ stopped selling tobacco on ______________ ❑ has never sold tobacco.
   months / years
4. Does your pharmacy advertise tobacco products? ❑ yes / ❑ no
5. When filling a patient's prescription, is he/she asked about tobacco use? ❑ yes / ❑ no
6. Do you sell tobacco replacement/cessation products including: ❑ patches / ❑ gum / ❑ other
   ____
7. Does a pharmacist counsel customers who purchase tobacco replacement products?
   ❑ yes / ❑ no

Comments: ____

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❑ **Please send me a free "PROUD TO BE TOBACCO FREE" decal for my window**

❑ **Please send me 100 free prescription bags that promote my pro-health pharmacy**

❑ **Yes, I give permission for my store name to appear in FREE advertisements honoring tobacco-free pharmacies in my County.**

Thank you for completing this survey.
Please FAX back to:

Prescription for Change

(415) 882-3392

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