MAILING ADDRESS:
MISSOURI BOARD OF PHARMACY
P.O. BOX 625
JEFFERSON CITY, MO 65102
(573) 751-0091
(573) 526-3464 (FAX)

DELIVERY ADDRESS:
3605 MISSOURI BOULEVARD
JEFFERSON CITY, MO 65109

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

PHARMACIST-IN-CHARGE STATEMENT
NEW AND CHANGE OF OWNERSHIP APPLICATIONS

1. Complete and give to the Inspector at the time of physical inspection; or
2. Mail along with the Pharmacy Self-Inspection for Change of Ownership form to address printed above.

DBA NAME OF PHARMACY (AS APPEARS ON PHARMACY PERMIT APPLICATION)	PERMIT NUMBER

STREET ADDRESS

CITY	STATE	ZIP CODE

	YES
1. Have you read and do you understand the laws of the State of Missouri relating to pharmacists and pharmacies as embodied in Chapter 195 and 338 Revised Statutes of the State of Missouri?	☐
2. Do you agree to observe and abide by all provisions of the above-named Missouri statutes?	☐
3. Do you agree to observe and abide by all lawful regulations promulgated and published by the Missouri Board of Pharmacy?	☐
4. Are you familiar with federal laws and regulations governing storing, dispensing, and sale of legend drugs and pharmaceuticals, specifically controlled drugs?	☐
5. Do you agree to observe and abide by all laws and regulations in #4 above?	☐
6. Do you understand and agree that no prescription will be compounded, sold or dispensed from your pharmacy except under the direct supervision of a pharmacist currently licensed in the State of Missouri?	☐
7. Do you understand and agree that no pharmaceutical items bearing the Federal “legend” shall be sold, dispensed or otherwise disposed of except by lawful means?	☐
8. Have you read and do you understand the pharmacist-in-charge requirements?	☐
9. Do you understand and agree that the pharmacist-in-charge is responsible for the professional and ethical conduct of the pharmacy?	☐
10. Do you agree that all persons involved in the operation of the pharmacy will be supervised by a Missouri licensed pharmacist at all times?	☐

THIS IS TO CERTIFY THAT I HAVE READ, ANSWERED, AND DO UNDERSTAND ALL OF THE ABOVE QUESTIONS AND AGREE TO ABIDE BY ALL OF THE ABOVE.

PHARMACIST-IN-CHARGE SIGNATURE	DATE

PRINT NAME