MISSOURI INTERIM SUPERVISING PHARMACIST DESIGNATION NOTIFICATION

SUBMIT THIS COMPLETED APPLICATION TO:	FOR OFFICE USE ONLY
E-MAIL: MissouriBOP@pr.mo.gov FACSIMILE: (573) 526-3464 (*E-mail is preferred*) ✓ **NO FEE IS REQUIRED** ✓ KEEP A COPY OF COMPLETED NOTIFICATION FOR YOUR RECORDS	RECEIVED PROCESS DATE/AUTHORIZED BY

SECTION A: PHARMACY INFORMATION

- *Complete this form if you currently hold a Missouri licensed pharmacy permit and are naming an Interim Supervising Pharmacist until a new Pharmacist-In-Charge (PIC) can be designated, as authorized by 20 CSR 2220-2.010(1)(M). No fee is required for this Notification Form.*
- *Missouri Resident Pharmacies: The Interim Supervising Pharmacists must hold a current and active Missouri pharmacist license.*
- *Non-Resident Pharmacies: The Interim Supervising Pharmacist must hold a current and active pharmacist license in the state where the pharmacy is located. The Interim Supervising Pharmacist's license must not be on discipline or otherwise restricted from serving as an Interim Supervising Pharmacist/PIC.*
- *The Board will document the Interim Supervising Pharmacist designation in the Board's records. The Interim Supervising Pharmacist will be reflected on the Board's website, however, a new pharmacy permit will not be issued to show the Interim Supervising Pharmacist.*
- *Interim Supervising Pharmacists may not supervise a pharmacy for more than thirty (30) days. A Missouri Change of Pharmacist-in-Charge Change application must be submitted to the Board with the applicable fee once a new pharmacist-in-charge is designated.*
- *A documented controlled substance inventory must be taken when the interim supervising pharmacist is designated.*

PHARMACY NAME	PHARMACY PERMIT #

PHARMACY ADDRESS (STREET)	(CITY)	(STATE)	(ZIP)

PHARMACY TELEPHONE #	PHARMACY FAX #

PHARMACY E-MAIL ADDRESS

INTERIM SUPERVISING PHARMACIST INFORMATION

FORMER PHARMACIST-IN-CHARGE NAME	FORMER PHARMACIST-IN-CHARGE LICENSE #

INTERIM SUPERVISING PHARMACIST NAME	INTERIM SUPERVISING PHARMACIST LICENSE #

EFFECTIVE DATE OF P.I.C. CHANGE/INTERIM SUPERVISING PHARMACIST DESIGNATION

Non-resident pharmacies located outside of Missouri must submit:

☐ A copy of the Interim Supervising Pharmacist's pharmacist license issued by the state where the pharmacy is located and

☐ An online pharmacist license verification from the issuing state Board of Pharmacy's/regulatory agency's official website for the Interim Supervising Pharmacist.

SECTION B: NOTIFICATION AFFIDAVIT

This affidavit must be signed by the Interim Supervising Pharmacy or a partner, corporate officer, or the sole proprietor named in the Board's records. Alternatively, the application may be signed by a person with a designated power of attorney authorizing the individual to sign and submit this application on the pharmacy's behalf. Proof of the designated power of attorney form must besubmitted with this application.

This application is hereby submitted on behalf of the pharmacy identified herein. I attest the foregoing application has been completed truthfully and accurately to the best of my knowledge and belief. I am making this affidavit knowing that any false statements or material omission may subject me or the entity identified herein to criminal penalties for making a false affidavit under Section 575.050, RSMo.

I understand that the applicant/pharmacy must comply with all applicable federal and state law(s) as well as the regulations of the Missouri Board of Pharmacy. -I hereby certify under penalty of perjury that the information and answers contained in herein and any attachments are true and correct to the best of my knowledge and belief.

SIGNATURE OF APPLICANT	**TITLE**
PRINT NAME	**DATE**

SECTION C: CONTACT PERSON

Please provide a contact person for questions from the Board office regarding this notification.

CONTACT NAME			**POSITION/TITLE**	
CONTACT MAILING ADDRESS	**(STREET)**	**(CITY)**	**(STATE)**	**(ZIP)**
CONTACT TELEPHONE #		**CONTACT FAX #**		
CONTACT E-MAIL ADDRESS				

INTERIM SUPERVISING PHARMACIST DESIGNATION STATEMENT
(MUST BE COMPLETED BY THE INTERIM SUPERVISING PHARMACIST)

PHARMACY NAME

PHARMACY ADDRESS **(STREET)** **(CITY)** **(STATE)** **(ZIP)**

DESIGNATED INTERIM SUPERVISING PHARMACIST NAME	**PHARMACIST LICENSE #**

INTERIM SUPERVISING PHARMACIST E-MAIL ADDRESS

ATTESTATION

I_____do solemnly swear or affirm that I am a licensed pharmacist in the state of _____ holding license number_____.

1. ☐ YES I agree that I will serve as the Interim Supervising Pharmacist of the pharmacy identified in this application.
2. ☐ YES I understand that I am personally responsible for ensuring the pharmacy's compliance with all applicable state and federal law governing the practice of pharmacy, controlled substances and drug distribution.
3. ☐ YES I understand that I may not serve as Interim Supervising Pharmacist for more than thirty (30) days.
4. ☐ YES I affirm that a controlled substance inventory has been taken, as required by 20 CSR 2220-2.010(1)(M).

All this I affirm under penalty of perjury.

MUST BE SIGNED IN THE PRESENCE OF A NOTARY

SIGNATURE OF NEW PHARMACIST-IN-CHARGE	PHARMACIST LICENSE #
PRINT NAME	DATE SIGNED

NOTARY PUBLIC EMBOSSER OF BLACK INK RUBBER SEAL STAMP	STATE SUBSCRIBED AND SWORN BEFORE ME, THIS _____ DAY OF_____YEAR _____	COUNTY (OR CITY OF ST. LOUIS)*