MISSOURI SUPERVISING PHARMACIST CHANGE APPLICATION (DRUG OUTSOURCERS)

SUBMIT THIS COMPLETED APPLICATION TO:	FOR OFFICE USE ONLY
MAILING ADDRESS **MISSOURI BOARD OF PHARMACY** P.O. BOX 625 JEFFERSON CITY, MO 65102 OVERNIGHT ADDRESS **MISSOURI BOARD OF PHARMACY** 3605 MISSOURI BOULEVARD JEFFERSON CITY, MO 65109 ✓ **$ 50.00 APPLICATION FEE. FEE IS NON-REFUNDABLE** ✓ KEEP COPY OF COMPLETED APPLICATION FOR YOUR RECORDS	LICENSE # ISSUE DATE / INSPECTOR RECEIVED

SECTION A: DRUG OUTSOURCER INFORMATION

- In the event the pharmacist designated with the board to supervise a drug outsourcer facility changes, the drug outsourcer may not continue operations until a new pharmacist is named to supervise the facility [20 CSR 2220-8.040(2)(B)]. The Drug Outsourcer facility may not continue operations until a new Supervising Pharmacist has been designated who meets Missouri's requirements. Once designated, the new Supervising Pharmacist may begin serving immediately. However, a fully completed Supervising Pharmacist Change application must be submitted to the board with the applicable fee within fifteen (15) calendar days after a new pharmacist is designated to supervise. Applications not received by the Board in a timely fashion may result in Board disciplinary review/action.
- The attached Supervising Pharmacist Statement must be submitted with this application.

DRUG OUTSOURCER NAME	**DRUG OUTSOURCER LICENSE #**

DRUG OUTSOURCER ADDRESS	**(STREET)**	**(CITY)**	**(STATE)**	**(ZIP)**

DRUG OUTSOURCER TELEPHONE #	**DRUG OUTSOURCER FAX #**

DRUG OUTSOURCER E-MAIL ADDRESS

SUPERVISING PHARMACIST INFORMATION

FORMER SUPERVISING PHARMACIST NAME	**FORMER SUPERVISING PHARMACIST LICENSE #**

NEW SUPERVISING PHARMACIST NAME	**NEW SUPERVISING PHARMACIST LICENSE #**

EFFECTIVE DATE OF SUPERVISING PHARMACIST CHANGE

NON-RESIDENT DRUG OUTSOURCERS:

If the designated Supervising Pharmacist is not a Missouri licensed pharmacist, non-resident pharmacies located outside of Missouri must also provide:

- ☐ The attached Pharmacist License Verification form. The form must be completed and sealed by the state agency that regulates and licenses pharmacists in the applicant's home state, OR;
- ☐ Online license verification documents printed from the pharmacy's state licensing authority will be accepted if the verification shows the pharmacy's disciplinary history.

SECTION B: CHARGES, CONVICTIONS, DISCIPLINARY ACTIONS AND STATUS

Answer all questions in this section. If you answer "yes" to any question, a detailed written explanation must be included with your application (*attach additional sheets if necessary*). Failure to include an explanation or to answer all of the questions will result in your application being rejected. If you are in doubt, answer "yes" and provide an explanation.

- **SUSPENDED IMPOSITION OF SENTENCE/SUSPENDED EXECUTION OF SENTENCE:** You are required to answer "yes" to the criminal history questions and to provide an explanation even if a Suspended Imposition of Sentence ("SIS") or Suspended Execution of Sentence ("SES") has been received. An attorney may advise you that you do not have to report SIS or SES information. However, the Board has access to both SIS and SES records. You must answer "yes" even if you received a SIS or a SES.

- If you answer "yes" to any of the criminal history questions, you must provide court documents that show the dates, charges and dispositions of your arrests/convictions. This typically includes copies of the charging document (complaint, indictment), the Judgment and Sentence and any other documents showing the disposition of your case.

- *338.185, RSMo, provides: "After August 28, 1990, notwithstanding any other provisions of law, the board of pharmacy shall have access to records involving an applicant for a license or permit or renewal of a license or permit as provided within this chapter, where the applicant has been adjudicated and found guilty or entered a plea of guilty or nolo contendere in a prosecution under the laws of any state or of the United States for any offense reasonably related to the qualifications, functions, or duties of any profession licensed or regulated under this chapter, for any offense an essential element of which is fraud, dishonesty or an act of violence or for any offense involving moral turpitude, whether or not sentence is imposed."*

1. Has the designated Supervising Pharmacist ever been found guilty or entered a plea of guilty or nolo contendere to a felony or misdemeanor in Missouri or in any other state, country or court (including federal court)? □ YES □ NO

2. Does the designated Supervising Pharmacist currently have any felony or misdemeanor criminal charges pending against them in Missouri or in any other state, country or court (including federal court)? □ YES □ NO

3. Has the designated Supervising Pharmacist ever received a Suspended Imposition of Sentence (SIS) or Suspended Execution of Sentence (SES) (felony or misdemeanor) in any criminal prosecution in Missouri or in any other state, country or court (including federal court)? □ YES □ NO

4. Has the designated Supervising Pharmacist ever been, or is now, addicted to any drugs, controlled substances or alcoholic beverages? □ YES □ NO

5. Has the designated Supervising Pharmacist ever had an application for a pharmacy technician, pharmacist, pharmacy intern, pharmacy, drug distributor or any other healthcare registration, license, permit, or certificate denied, disciplined or refused in this state, or any other state or country? *(If yes, copies of any denial/refusal/disciplinary documents must be provided)* □ YES □ NO

6. Has the designated Supervising Pharmacist ever had any controlled substance registration, license, permit, or certificate denied, disciplined or refused in this state, or any other state or country? *(If yes, copies of any denial/refusal/disciplinary documents must be provided)* □ YES □ NO

7. Has the designated Supervising Pharmacist ever been adjudged insane or incompetent by or in any state, court or country? □ YES □ NO

MILITARY BENEFITS/SERVICE

Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable? ☐ YES ☐ NO

Would you like to receive information and assistance regarding veterans benefits and services? ☐ YES ☐ NO

May the agency share your contact information with the Missouri Veterans Commission to provide such information? General information may also be found on the Missouri Veterans Commission's website https://mvc.dps.mo.gov/. ☐ YES ☐ NO

SECTION C: APPLICANT AFFIDAVIT

This affidavit must be signed by the Supervising Pharmacist 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 Drug Outsourcer's behalf. Proof of the designated power of attorney form must be submitted with this application.

This application is hereby submitted on behalf of the Drug Outsourcer 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/Drug Outsourcer 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 D: APPLICATION CONTACT PERSON

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

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

Supervising Pharmacist Change Application

SUPERVISING PHARMACIST STATEMENT
(MUST BE COMPLETED BY THE DESIGNATED SUPERVISING PHARMACIST)

DRUG OUTSOURCER NAME				
DRUG OUTSOURCER ADDRESS	**(STREET)**	**(CITY)**	**(STATE)**	**(ZIP)**

DESIGNATED SUPERVISING PHARMACIST NAME	**PHARMACIST LICENSE #**
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. I agree that I will serve as the Supervising Pharmacist of the Drug Outsourcer identified in this application. □ YES
2. I understand that the license will be issued to the applicant with my name appearing as Supervising Pharmacist. □ YES
3. I understand that I am personally responsible for ensuring the Drug Outsourcer's compliance with all applicable state and federal law governing drug outsourcing activity, controlled substances and drug distribution. □ YES
4. If my designation as Supervising Pharmacist is ended/changed for any reason, I will immediately notify the Missouri Board of Pharmacy. □ YES

All this I affirm under penalty of perjury.

MUST BE SIGNED IN THE PRESENCE OF A NOTARY

SIGNATURE OF NEW SUPERVISING PHARMACIST	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)