Missouri Drug Outsourcer Application

SUPERVISING PHARMACIST STATEMENT

(Must be completed by the designated supervising pharmacist)

DRUG OUTSOURCER NAME

FACILITY ADDRESS (STREET) (CITY) (STATE) (ZIP)

DESIGNATED SUPERVISING PHARMACIST NAME

DESIGNATED SUPERVISING PHARMACIST PHONE #

DESIGNATED SUPERVISING PHARMACIST E-MAIL ADDRESS

ATTESTATION

I_____do solemnly swear or affirm that:

1. I agree that I will serve as the supervising pharmacist of the drug outsourcer (drug outsourcer) identified in this application. ☐ YES
2. I hold a current and active pharmacist license in a U.S. state or territory. ☐ YES
3. I understand that the drug outsourcer license will be issued to the applicant with my name appearing as supervising pharmacist. ☐ YES
4. I understand that I am personally responsible for ensuring the drug outsourcer's compliance with all applicable state and federal law governing controlled substances and drug outsourcer activity. ☐ YES
5. 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 PROPOSED 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)