For office use only

Permit #_____

Validation #_____

Alabama State Board of Pharmacy
111 Village Street
Birmingham, AL 35242
Phone 205-981-2280
Fax 205-981-2330
Website: www.albop.com

NOTIFICATION OF CHANGE OF SUPERVISING PHARMACIST

680-X-2-.12. SUPERVISING PHARMACIST Reads in part….

(1) Every Pharmacy shall be under direct supervision and control of a registered Pharmacist who shall be designated the supervising pharmacist. The supervising pharmacist shall be responsible for no more than one Pharmacy and in which Pharmacy he/she practices. …….. The supervising pharmacist shall be on duty a minimum of 50% of the hours the pharmacy is in operation or at least thirty (30) hours per week, whichever is less.

(2) Whenever a registered Pharmacist assumes the duties of a supervising pharmacist he/she shall, within ten (10) days, so advise the Board by completing the 'Notice of Change of Supervising Pharmacist' form provided by the Board.

(3) Whenever there is a new supervising pharmacist he/she shall be required to take an inventory of all controlled substances as defined in Title 20, Chapter 2, Code of Alabama 1975, within fifteen (15) days.

(7) The permit holder is responsible and accountable for assuring the supervising pharmacist is working the designated hours set by the Board and for the renewal of the pharmacy permit.

(8) If the permit holder is unable to maintain a designated supervising pharmacist, the permit holder shall notify the Board within ten (10) days with an action plan to designate another pharmacist as supervising pharmacist. This plan can be for a period not to exceed ninety (90) days before the permit is in violation for operating without a supervising pharmacist.

PERMIT INFORMATION:

Pharmacy Name:_____Permit #:_____

Pharmacy Address:_____City_____State_____ Zip:_____

DEPARTING SUPERVISING PHARMACIST:

Name: (print)_____License #_____

Pharmacist Signature:_____Date of Departure_____

NEW SUPERVISING PHARMACIST:

Name: (print)_____License #_____

Pharmacist Signature:_____Effective Date:_____

List the #of Hours worked per week_____

TO OBTAIN A REPRINTED PERMIT WITH THE NEW SUPERVISING PHARMACIST NAME, ENCLOSE A CHECK OR MONEY ORDER IN THE AMOUNT OF $10 PAYABLE TO THE ALABAMA STATE BOARD OF PHARMACY.