NOTIFICATION OF CHANGE OF SUPERVISING PHARMACIST

Pharmacy Name: _________________________________Pharmacy License Number________________
Street: ____
City: ___________________________________ State________________ Zip Code_________________
Date of inventory of controlled substances: _______ Who participated in the controlled substance inventory? ☐ Incoming PIC ☐ Outgoing PIC (Please attach copy of inventory)

680-X-2.12. SUPERVISING PHARMACIST ***Reads in part….***

(1) Every Pharmacy shall be under the 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 that 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/shall, within ten (10) days, so advise the Board by completing the 'Notice of Change in Supervising Pharmacist' form provided by the Board.
(3) Whenever there is a new supervising pharmacy 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.

By my signature, I acknowledge that I am the supervising pharmacist of this pharmacy, and the required change of Supervising Pharmacist inventory has been taken. I further attest that I have read and understand the laws and rules relating to this class of pharmacy.

Incoming Supervising Pharmacist:

Printed Name____ License Number ________________________
Signature ____ Start Date____________________________

Departing Supervising Pharmacist:

Printed Name____ License Number ______________________
Signature ____ End Date _____________________________
Will you remain on staff? Yes ____ or No _____

This form is for the purpose of change of supervising pharmacist only – all other employment changes should be submitted online under My Profile on our website www.albop.com.

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
111 Village Street
Birmingham, AL 35242
Phone (205-981-2280) Fax (205-803-6431)