



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)