

PH205

The University Of The State Of New York  
The State Education Department  
Board Of Pharmacy  
Email: pharmbd@mail.nysed.gov  
Web: www.op.nysed.gov/prof/pharm.htm

Department Use Only  
Date Stamp

## Notice of Change of Supervising Pharmacist

"The state board of pharmacy shall be notified within seven days of any change in the identity of the supervising pharmacist of a registered establishment. Such notification shall be made by the owner of the registered establishment." (Rules of the Board of Regents, part 29.7 (a)(10))

The pharmacy must be supervised by a New York State registered pharmacist at all times while open. A pharmacy found in violation will be referred to the Office of Professional Discipline for investigation.

**Instructions:** Complete this form and forward to the NYS State Board of Pharmacy by fax at 518-473-6995, or by mail to 89 Washington Avenue, 2nd Floor West, Albany, NY 12234-1000. Failure to provide complete and accurate information will result in referral to the Office of Professional Discipline for investigation.

Date SP Entered

Initials

Notes

Registered Name of Pharmacy: \_\_\_\_\_

Address of Pharmacy: \_\_\_\_\_

Pharmacy Registration No.: \_\_\_\_\_ Registration Period Ending: \_\_\_\_\_

### This section must be completed by the Supervising Pharmacist

I, \_\_\_\_\_, do hereby certify that I replaced \_\_\_\_\_ as Supervising Pharmacist of the pharmacy designated above, on \_\_\_\_\_ (Month/Day/Year).

I do hereby certify that I am a licensed pharmacist, currently registered, holding license number \_\_\_\_\_, dated \_\_\_\_\_, and that I am employed for \_\_\_\_\_ hours a week at this pharmacy.

I further certify that I have full knowledge of my professional responsibilities as Supervising Pharmacist and will discharge my responsibilities to the best of my ability. This Pharmacy is open for business \_\_\_\_\_ hours each week.

Signature of **Supervising Pharmacist**

Date

Print Name

Signature of **Proprietor, Corporate Officer, or Authorized Individual** (Needs power of attorney) Date

Print Name

Title