

\*\*\* Submit This Cover Page With Application \*\*\*

\*\*\*FOR OFFICE USE ONLY\*\*\*



**Rhode Island  
Board of Pharmacy**

Room 103  
3 Capitol Hill  
Providence, RI 02908-5097

Receipt #:

ID#:

Issue Date:

License # **PHB**  
**CPHB**

***Instructions and Application For***

**Pharmacy - Institutional License  
and  
Controlled Substances Registration**

- |   |   |
|---|---|
| <input type="checkbox"/> New Application                    | <input type="checkbox"/> Change of Location (License # _____ )  |
| <input type="checkbox"/> Controlled Substances Registration | <input type="checkbox"/> Change in Ownership (License # _____ ) |

**Practice Specialty:**

Hospital

HMO

Empty rectangular box for applicant information.

*Applicant - Print Pharmacy/Facility Name*

**Phone: (401) 222-2837**

**TTY/TDD: (800) 745-5555**

**Fax: (401) 222-2158**

## GENERAL INFORMATION

### Enclosures

The following materials and information should be enclosed within this application packet:

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Application.....	6-10
Application Checklist.....	11
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### Licensure Requirements

- Application Fee of **\$220.00** (add \$100.00 for Controlled Substances Registration for a total of **\$320.00**)  
Check or money order only (**NOTE:** All application fees are **non-refundable**)
- Federal Drug Enforcement Administration (DEA) Registration (if applicable)
- Pharmacist-in-Charge
- Blueprint or Floor Plan Drawings (for new pharmacy or change of location only)
- Inspection (for new pharmacy or change of location only)

### Pharmacist-in-Charge

The pharmacist-in-charge is a pharmacist licensed in this state that is designated by the owner as the person responsible for the operation of a pharmacy, and who is personally in full and actual charge of such pharmacy and personnel. The pharmacist-in-charge is responsible for meeting the requirements set forth by federal and state law, the Pharmacy Act, and other applicable regulations of the BOARD.

### Physician ownership

The Board of Pharmacy shall refuse to grant any pharmacy license to any person who is a practitioner authorized to prescribe medications or to any partnership, corporation or other entity in which practitioners authorized to prescribe medications maintain a financial interest which, in the aggregate, exceeds ten percent (10%) of the total ownership of said entity or of the subject pharmacy or drug store. "Financial interest" means financial benefit gained by any practitioner with authority to prescribe drugs and includes such benefit derived by a spouse or dependent child. **Information regarding practitioner ownership and financial interest must be provided along with this application.**

On and after July 1, 1994, good and sufficient cause shall exist for the refusal to renew and/or for the revocation of any pharmacy license, if, after hearing, the Board of Pharmacy determines that:

- i. Practitioners, spouse (if not estranged) or any dependent child or business associate of the person with authority to prescribe medications maintain a financial interest, which, in the aggregate, exceeds ten percent (10%) of the total ownership of the subject pharmacy, drug store or licensee; or*
- ii. More than forty percent (40%) of the prescriptions filled by the subject pharmacy or drug store within any three (3) month period beginning on or after July 1, 1994 were issued by practitioners with any ownership interest in a drug store or licensee.*
  - a. The pharmacist-in-charge of said pharmacy shall furnish and deliver to the Board, upon request, all dispensing reports, and any other required documents necessary to determine the percentage of prescriptions filled.

# APPLICATION PROCESS OVERVIEW

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The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professions Regulation, and the Rhode Island Board of Pharmacy (BOARD).

## **Application Process**

This application is to be used for a new institutional pharmacy, and to apply for a new license due to a change in ownership or location. Copies of the current continuing education credits for the pharmacist-in-charge must accompany this application. A pharmacy license will be issued to a person, owner, corporation, or other legal entity, hereinafter called the "Licensee". The license shall entitle the owner to operate such pharmacy at the location specified and shall not be transferred. The license shall be posted in a conspicuous place on the licensed premises. When there is a change in ownership, operation and/or location, the license immediately becomes void and shall be delivered by the licensee to the BOARD. It is the duty of the owner to immediately notify the BOARD of any proposed change of location or ownership, and to file the required application prior to the change.

### **"Change of ownership" means:**

- a. In the case of a pharmacy, manufacturer or wholesaler which is a partnership which results in a new partner acquiring a controlling interest in the partnership;
- b. In the case of a pharmacy, manufacturer or wholesaler which is a sole proprietorship, the transfer of the title and property to another person;
- c. In the case of a pharmacy, manufacturer or wholesaler which is a corporation:
  - i. A sale, lease exchange, or other disposition of all, or substantially all of the property and assets of the corporation; or
  - ii. A merger of the corporation into another corporation; or
  - iii. The consolidation of two or more corporations, resulting in the creation of a new corporation; or
  - iv. In the case of a pharmacy, manufacturer or wholesaler which is a business corporation, any transfer of corporate stock which results in a new person acquiring a controlling interest in the corporation; or
  - v. In the case of a pharmacy, manufacturer or wholesaler which is a nonbusiness corporation, any change in membership which results in a new person acquiring a controlling vote in the corporation.

Renovating or remodeling an existing pharmacy is not considered a change of location. Written notification to the BOARD is required prior to the renovations or remodeling, stipulating the expected date of completion, and accompanied by the blueprints of the proposed changes.

All items listed on the "checklist" (page 11) must be submitted for an application to be considered complete. All applications are considered valid for six months from the day they are received at HEALTH. If you do not complete the application process and obtain a license within those six months, a new application and fee must be submitted.

A new pharmacy, or a relocation of an existing pharmacy, must be inspected prior to the issuance of a license. It is the applicant's responsibility to contact the BOARD to schedule an inspection. Please allow a minimum of four weeks for the entire licensure process to be completed. If the applicant has had criminal or disciplinary history in Rhode Island or another state, it may take an additional two or three months for all pertinent documentation to be received, and a decision to be made regarding the issuance of a license. This is an estimate of the amount of time that is required to become licensed. The entire process may take more or less time than estimated.

## APPLICATION PROCESS OVERVIEW (continued)

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Licenses will be issued within five working days following the Board's approval of the completed application. Wall permits are mailed approximately two weeks from the date of issuance, and are mailed to the address furnished in the application. It is the applicant's responsibility to notify the BOARD, in writing, if there are changes during the interim, or at any time after the license is issued. It is the responsibility of the licensee to notify the BOARD in writing when there is a change in the pharmacist-in-charge. **At no time can a pharmacy operate without a designated pharmacist-in-charge on file with the BOARD.**

HEALTH will not, for any reason, accelerate processing of one applicant at the expense of other applicants. Once completed, the application will be reviewed, and will be contacted by the BOARD if further information is required. Be advised, the applicant may be required to appear for an interview.

### NOTE:

Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal Law.

The license will expire on September 30th (***regardless of the date issued***), and a form will be mailed to renew the pharmacy license for the period October 1st through September 30th. It is the licensee's responsibility to maintain an active license. If a renewal is not received, the licensee is to contact the BOARD to follow-up on the status of the renewal:

<https://healthri.mylicense.com/Verification/>

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the Board application. If you have any questions about this application process, or would like to check on the status of your BOARD application, please contact the BOARD at (401) 222-2837.

### **Rules and Regulations**

To obtain the Rules and Regulations for your profession visit the A-Z list on the Topics & Programs page at the following web site. From the list click on the letter for your profession.

<http://www.health.ri.gov/atoz/>

## INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

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Read the following instructions and those throughout the application packet carefully before completing the Board application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays. All of the information provided is subject to change.

### General Instructions

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type the information or print in blue or black ball-point pen. Board staff will not make assumptions about illegible information. Be sure to print the licensee's name in the box provided on the cover page.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. It is suggested that a copy of the completed application be made before submitting it to the Board.
5. It is the applicant's responsibility to check on the status of the application.

### Completing your Board Application

1. Complete the **Board Application** pages (6-10). Respond to all components of the application as instructed. If you attach separate pages in continuation of the Board application, such pages **MUST** clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the application fee of **\$220.00** (or **\$320.00** with CSR application) payable to **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the cover page of the application.

A Controlled Substances Registration (CSR) is mandatory for all new pharmacies that will dispense controlled substances. The fees are **NONREFUNDABLE**. A Drug Enforcement Administration (DEA) Registration is also required. **Contact the DEA at 617-557-2200 for the application**

[http://www.dea diversion.usdoj.gov/drugreg/reg\\_apps/index.html](http://www.dea diversion.usdoj.gov/drugreg/reg_apps/index.html)

**The RI CSR is contingent upon a DEA Registration being issued.**

Complete all application materials as instructed and arrange them in order as they appear in the application checklist (see page 11). Do not submit applications without all applicable information, documentation and fee. Mail these components of the application to:

**Rhode Island Department of Health  
Board of Pharmacy, Room 103  
3 Capitol Hill  
Providence, RI 02908-5097**



# State of Rhode Island Board of Pharmacy

Application for Pharmacy - Institutional

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

### 1. Facility Name:

Facility Name

### 2. Pharmacist-in-Charge

Provide the name of the pharmacist who is responsible for the day-to-day operations of the pharmacy.  
**NOTE:** A change in the Pharmacist-in-Charge requires written notification to the BOARD.

Pharmacist License Number

First Name

Middle Name

Surname (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Area Code

Phone Number

Extension

Unlisted?

### 3. Facility Mailing Information:

Please provide the mailing information for all communication regarding this license. It is your responsibility to notify the board of all address changes.

***This information will NOT appear on the HEALTH Web site.***

First Line Address

Second Line Address

Third Line Address

City

State

Zip Code

Country, if NOT U.S.

Postal Code, if NOT U.S.

Mailing Address Phone

Extension

Mailing Address Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

### 4. Facility Location Information:

It is your responsibility to notify the board of all address changes.

***This information will appear on the HEALTH Web site.***

First Line Address

Second Line Address

Third Line Address

City

State

Zip Code

Country

Postal Code, if NOT U.S.

Facility Phone

Extension

Facility Fax

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

### 5. Type of Ownership

Please Check ONE

Corporation  Limited Liability Company  Partner

Sole Proprietorship  Limited Partnership  Partnership

Governmental Entity  Other (Describe):

**6. Ownership Information:**

Provide the name address and telephone number(s) of the facility/ business owner in the spaces provided.

**NOTE:**

**If practitioner ownership, please provide aggregate financial interest and attach information to this application.**

Name of Owner									
D.B.A. (Doing Business As)									
First Line Address									
Second Line Address									
Third Line Address									
City					State/Province		Zip Code		
Country, if NOT U.S.					Postal Code, if NOT U.S.				
Facility Phone			Extension			Facility Fax			
Email Address (Format for email address is Username@domain e.g. applicant@isp.com)									
U.S. Social Security Number (SSN)					<p><b>“Pursuant to Title 5, Chapter 76, of the Rhode Island General Laws, as amended, I attest that I have filed all applicable tax returns and paid all taxes owed to the State of Rhode Island, and I understand that my Social Security Number (SSN)//Federal Employer Identification Number (FEIN) will be transmitted to the Division of Taxation to verify that no taxes are owed to the State.”</b></p>				
Federal Employer Identification Number (FEIN)									

**NOTE:** If you are the sole proprietor of a facility or business, then you must supply your Social Security Number (SSN). If you are an individual representing a facility or a business that is seeking licensure, then you must supply the Federal Employer Identification Number (FEIN) for the facility or the business.

**7. NCPDP#:**

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NCPDP Number (no dashes)

National Council for Prescription Drug Programs Number (NCPDP)  
[formerly know an National Association of Board of Pharmacy Number (NABP#)]

Applicant: Print your complete business name >

### 8. Pharmacy Personnel

List names and license numbers of all personnel employed in the pharmacy, and indicate whether their employment is full time or part time.

Attach a separate page if necessary.

A licensed pharmacist must be present at all times the pharmacy is open.

**NOTE:**

It is the responsibility of the Pharmacist-in-Charge to ensure that only those individuals with active licenses are permitted access into the pharmacy. Verifications of Licensure can be printed from the following web site:

[www.health.ri.gov/hsr/professions/license.php](http://www.health.ri.gov/hsr/professions/license.php)

**Pharmacists**

_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		

**Pharmacy Interns**

_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		

**Pharmacy Technicians**

_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
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Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		
_____	_____	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T
Name	License Number		



**9. Rhode Island Controlled Substances Registration (CSR)\***

Complete this area to apply for a registration to dispense and possess controlled substances in the State of Rhode Island (*additional fee required*).

**NOTE: The CSR is renewed at the same time as the pharmacy license.**

**Do you wish to apply for a Rhode Island Controlled Substances Registration?**

Yes     No    If "Yes", the additional fee must be included in the attached payment

**Drug Schedules - Check all applicable**


Schedule I Attach Protocol     Schedule II     Schedule III     Schedule IV     Schedule V

**Drug Enforcement Administration (DEA Registration)**

    Pending\*\*  
DEA Number

\*A CSR is not required if there are no controlled substances stored or dispensed on the premises.

**\*\*A copy of the DEA Registration must be provided to the BOARD within 60 Days of issuance.**

*Carefully*  *read this section.*

**IMPORTANT INFORMATION**

Licensed pharmacies cannot dispense or possess controlled substances in the State of Rhode Island without a valid professional license, Rhode Island Controlled Substances Registration (CSR), and a federal Drug Enforcement Administration (DEA) Registration. "Controlled Substances" for purposes of this application, means a prescription drug in Schedules II through V, pursuant to the Rhode Island Uniform Controlled Substances Act, and 21 CFR 1300 of the Federal Code of Regulations. Schedule I drugs are used by researchers, and require the submission of a protocol.

Without a Rhode Island CSR, and federal DEA Registration, pharmacies may dispense or possess non-controlled prescription medications under its pharmacy license. No CSR will be granted to a pharmacy applicant whose application is "pending" in this state.

All applicants must make application to the U.S. Drug Enforcement Administration for a federal registration. Federal regulations require that applicants comply with individual state requirements before they are issued a DEA Registration.

**Registration Unit  
US Drug Enforcement Administration  
JFK Federal Building  
15 New Sudbury Street  
Boston MA 02203-0131  
(617) 557-2200**

Issuance of a Rhode Island Controlled Substances Registration is contingent upon registration from the U.S. Drug Enforcement Administration. If denied a "DEA Registration", the Rhode Island Controlled Substances Registration becomes "VOID".

**\*\*A copy of the DEA Registration must be provided to the BOARD within 60 days of its issuance.**

**10. Affidavit of Applicant**

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I hereby authorize all hospital(s), institution(s) or organizations(s), my references, personal physicians, employers (past and present) and all governmental agencies and instrumentality's (local, state, federal or foreign) to release to the Rhode Island Board of Pharmacy any information which is material to my application for licensure.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice pharmacy in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Board of Pharmacy of any change in the answers to these questions after this application and this affidavit is signed.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date of Signature (MM/DD/YY)

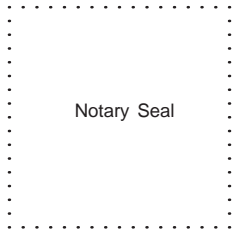
**The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, by \_\_\_\_\_, who is personally known to me or has produced \_\_\_\_\_ as documentation and did / did not take an oath.**

\_\_\_\_\_  
Name of Notary (Print, Type or Stamp)

\_\_\_\_\_  
Signature of Notary

\_\_\_\_\_  
Notary No/Commission No.

\_\_\_\_\_  
Commission Expiration Date (MM/DD/YY)



## APPLICATION CHECKLIST

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Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

### Board Application

- I have read and understand the "Instructions for Completing the Application".
- I have completed the Rhode Island Board application as instructed (pages 6-10).
- I have removed the "General Information", "Overview" and "Instructions" sections and have attached the cover page to the top of the remainder of the application.
- I have completed Section 9, "**Affidavit of Applicant**", and had the form notarized by a notary public.
- I have a **check or money order** (preferred), made payable (in U.S. funds only) to the "**RI General Treasurer**" in the amount of **\$220.00 (\$320.00 with CSR)** and attached it to the upper left-hand corner of the cover (Top) page of the application.
- I have arranged my Board Application materials in the following order.
  1. Fee (attached as instructed).
  2. Board Application (includes cover page and pages 6-10).
  3. Supporting documentation as required [**Note:** Pages containing additional information in continuation of the Board application **MUST** indicate the section for which the information is being reported].
  4. Copies of the Pharmacist-in-Charge's continuing education documents for the current renewal period.
  5. Set of blueprints or plans of the proposed pharmacy (new pharmacy or change of location **ONLY**).
  6. A complete list of all direct or indirect owners with percentages of ownership indicated.
- I have mailed the above application materials directly to the Rhode Island Department of Health, Board of Pharmacy.
- I have contacted the Drug Enforcement Administration concerning a federal DEA Controlled Substances Registration (CSR), if applicable.



RHODE ISLAND DEPARTMENT OF HEALTH  
Division of Health Services Regulation  
Board of Pharmacy  
3 Capitol Hill  
Providence, RI 02908-5097  
Phone: (401) 222-2837

**Termination as Pharmacist-In-Charge Report**

TO: Rhode Island Board of Pharmacy

FROM: \_\_\_\_\_  
Pharmacy Name \_\_\_\_\_ License Number \_\_\_\_\_  
Pharmacy Address \_\_\_\_\_  
Pharmacy City, State, Zip Code \_\_\_\_\_

**SUBJECT: TERMINATION AS PHARMACIST-IN-CHARGE**

The following pharmacist is no longer the Pharmacist-in-Charge at the location listed below.

\_\_\_\_\_  
Name \_\_\_\_\_ License Number \_\_\_\_\_  
\_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_ Effective Date \_\_\_\_\_

The new Pharmacist-in-Charge is:

\_\_\_\_\_  
Name \_\_\_\_\_ License Number \_\_\_\_\_  
\_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_ Effective Date \_\_\_\_\_

The closing inventory of **Schedule II's**, and a separate inventory of **Schedules III-V** has been/will be completed and a copy will be mailed to the BOARD.

\_\_\_\_\_  
Printed Name \_\_\_\_\_ Title \_\_\_\_\_  
\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**State of Rhode Island**  
**DEPARTMENT OF HEALTH**  
**Board of Pharmacy**

**RESPONSIBILITIES OF PHARMACIST-IN-CHARGE**

To be the pharmacist-in-charge of a pharmacy is a responsibility which the Board of Pharmacy deems very important. The pharmacist-in-charge is responsible for ensuring compliance with all federal and state laws, and rules and regulations pertaining thereto. The BOARD would like to take this opportunity to advise the pharmacist-in-charge of some of the responsibilities. Please note ... this list is not all inclusive.

The pharmacist-in-charge shall be responsible for no less than the following.

- Provide to the Board of Pharmacy, a beginning inventory of all controlled substances, Schedules II-V, upon commencement of duties, and an ending inventory of same upon termination of duties as pharmacist-in-charge.
- Maintain adequate controls against the diversion of controlled substances, and shall promptly execute DEA Form 106 (or its successor form) to the Drug Enforcement Administration and the BOARD in the event of a theft or loss of a controlled substance.
- Report prescription forgeries, or attempted forgeries, as deemed necessary in the professional judgement of the pharmacist-in-charge to appropriate law enforcement agencies.
- Ensure that the pharmacy dispensing area and equipment is in clean and orderly condition, that all licenses and registrations are current. that the "top-ten" list and prices are conspicuously posted, and that the expiration dates of the pharmaceutical stock are periodically checked to ensure that no expired medications are dispensed.
- Ensure that an adequate number of qualified, competent and trained pharmacists are employed.
- Remove all controlled and non-controlled drugs from any pharmacy or institution upon sale or closure of the facility.
- Comply with the Rules and Regulations Governing the Disposal of Legend Drugs (R21-31-LEG) promulgated by HEALTH, to utilize an alternative drug destruction mechanism for expired, excess/undesired controlled substances consistent with federal and state laws.
- Contact the BOARD whenever a concern arises that would affect the pharmacy's practice.
- Ensure adherence to all policies and procedures for the operation of the pharmacy in accordance with the Act and the rules and regulations.
- Be administratively responsible for the overall operation and conduct of the pharmacy.