



State of Maine

BOARD OF PHARMACY

Emergency Pharmacist-In-Charge Waiver Request

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation
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EMERGENCY PHARMACIST-IN-CHARGE WAIVER REQUEST

(Pharmacy Rules Chapter 13 Section 3 (5))

A request for approval pursuant to Section 3(4)(A) of Chapter 13 must be made within 7 days after the death, incapacity, commencement of emergency medical leave or unexpected resignation or discharge of a pharmacist in charge. Providing that the request is made within this time period,

- A. The board administrator or the administrator's designee may rule on the request on an interim basis until the board is able to address it; and
- B. The retail pharmacy may operate under the supervision of a pharmacist pending the interim ruling of the board administrator or the administrator's designee.

A pharmacist must be named to act as the interim pharmacist in charge and the appropriate Pharmacist in Charge application form must be submitted with this request for an emergency waiver. The pharmacy owner must be prepared to appear before the board at the next available meeting of the board. A notice of the date, time and location of the meeting will be sent by the board office.

SECTION 1:

Out Going Pharmacist in Charge (PIC) – Last, First, Middle (print legibly)	License number
Circumstance	
<input type="checkbox"/> Death Date of Death _____	
<input type="checkbox"/> Incapacity, explain: _____ _____ _____	
<input type="checkbox"/> Emergency medical leave Date emergency medial leave began: _____	
If known, date PIC may be expected back to work: _____	
<input type="checkbox"/> Unexpected resignation Date of Resignation: _____	
<input type="checkbox"/> Unexpected discharge Date of Discharge: _____	
Reason for discharge: _____	

Initial _____

<input type="checkbox"/> Check here if this is a <u>Specialty practice setting</u> which does not require a pharmacist in charge to be present at least 30 hours per week minimum or 50% of the setting's normal hours (e.g., opiate treatment program). Attach a detailed letter of explanation. (Requires Board Action)
<input type="checkbox"/> Check here if other situation where exigent circumstances warrant the registration of a sole pharmacist in charge of more than one retail drug outlet. Attach a detailed letter of explanation (Requires Board Action)

SECTION 2: The Board of Pharmacy holds the Supervising Pharmacist responsible for all pharmacy related matters.

Supervising Pharmacist Name (Acting as PIC) – Last, First, Middle (print legibly)			
Pharmacist License Number		Expiration Date	
Contact Address of Pharmacist	City	State	Zip Code
E-mail Address			
Date Beginning as Supervising Pharmacist		Expected End Date as Supervising Pharmacist	

SECTION 3:

Pharmacy Name			
DEA #		Expiration Date	
License Number		Expiration Date	FEIN #
Physical Address	City	State	Zip Code
Contact Address	City	State	Zip Code
Telephone Number		Fax Number	
()		()	
E-mail Address			

Initial _____

SECTION 4: THIS SECTION MUST BE COMPLETED BY THE SUPERVISING PHARMACIST NAMED AS ACTING PHARMACIST IN CHARGE (“PIC”). Check appropriate response to the questions below. Any YES response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

<p>Have you ever been denied registration by the U.S. Drug Enforcement Administration (DEA) or have you ever had a DEA Registration modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked your state permit to prescribe or dispense controlled substances? If yes:</p> <p>1. <input type="checkbox"/> DEA action <input type="checkbox"/> Other State of Province (Name) _____</p> <p>2. Submit a copy of the official action by the entity.</p> <p>3. Provide a detailed explanation in your own words on a separate sheet of paper.</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p>Have you ever received a sanction from Medicare or from a state Medicaid program?</p> <p>1. <input type="checkbox"/> Medicare OR <input type="checkbox"/> Medicaid Program (State) _____</p> <p>2. Submit a copy of the official action by the entity.</p> <p>3. Provide a detailed explanation in your own words on a separate sheet of paper.</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>

SECTION 5: NOTICES

⇒ **Public Information**

This application is a public record for purposes of Maine’s Freedom of Access Law, 1 MRS §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State’s website.

⇒ **Notice Regarding Social Security Number Disclosure**

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRS section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRSA §191.

Initial _____

SECTION 5: continued

⇒10 Day Notification Requirement

This applicant/licensee must report in writing to the Board the following information no later than 10 days after the change or event, as the case may be:

- a. Change of name or address of the licensee;
- b. A criminal conviction of the licensee or anyone listed on this application as having an ownership interest in the licensee;
- c. A revocation, suspension, or other disciplinary action taken in this or any other jurisdiction against any occupational or professional license held by the applicant/licensee or anyone listed on this application as having an ownership interest in the licensee; or
- d. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the Board.

SECTION 6: APPLICANT'S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application.

By signing this application, I attest as the Interim Pharmacist in Charge that I will be present in the pharmacy a minimum of 30 hours, or 50 percent of the hours the pharmacy is open, which ever is less as required by board rules.

By signing this application, I acknowledge that I have read, understand, and agree to uphold the Laws and Rules of the Board and the requirements and duties of a pharmacist in charge (32 MRS §§ 13752 (2)(1)). I have been notified that my name may be reported to various disciplinary data banks if I am sanctioned by the Maine State Board of Pharmacy for violating the Board's Laws and/or Rules and that I have answered the above questions. By submitting this application I understand that the Board of Pharmacy will rely upon this information for issuance of my license to be a pharmacist in charge and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension, or revocation of my license if this information is found to be false.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

Printed Name of Interim Pharmacist in Charge	
Signature of Interim Pharmacist in Charge	Date