



APPLICATION FOR UNANTICIPATED TEMPORARY PHARMACY CLOSURE

Form 4B
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PART 1: Complete Part 1 and submit a copy to the College as soon as possible, then complete Part 2 when the pharmacy has re-opened.

1. INFORMATION OF PHARMACY

Operating Name		Pharmacy Licence Number	
Pharmacy Address	City	Province BC	Postal Code
Email Address	Phone Number	Fax Number	
Reason for Temporary Closure <input type="checkbox"/> Flood/Water Damage <input type="checkbox"/> Fire <input type="checkbox"/> Wildfires/Evacuation Order <input type="checkbox"/> Earthquake <input type="checkbox"/> Structural Damage <input type="checkbox"/> Other – Specify: _____	Temporary Closure Start Date MMM DD YYYY	Anticipated Re-opening Date MMM DD YYYY	

PHARMACY MANAGER

- I have read and understand my duties and responsibilities for the pharmacy before and during the period of the unanticipated temporary closure as required in section 18(2)(dd) of the [PODSA Bylaws](#) and [PPP-46](#).
- I have taken steps to ensure that the pharmacy is compliant with the security requirements set out in section 26 of the [PODSA Bylaws](#) so that drugs and patient medications and prescription records are securely stored during this period.
- I understand that should any drugs be rendered useless, I will destroy them appropriately and in accordance with applicable bylaws and College policies such as [PPP-65](#).

Manager Name	Registration Number	Signature	Date MMM DD YYYY
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DIRECT OWNER

- I have read and understand the duties and responsibilities pertaining to the pharmacy during the unanticipated temporary closure period as required in section 18(2)(dd) of the [PODSA Bylaws](#).

Name of Authorized Representative (AR)	Signature	Date MMM DD YYYY
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PART 2: Complete Part 2 and submit a copy to the College no later than 2 weeks from the actual re-opening date of the pharmacy.

Note: Your pharmacy will not be listed as an active licensed pharmacy on the College website until the College receives this Part of the form.

2. CONFIRMATION OF PHARMACY RE-OPENING

Operating Name	Pharmacy Licence Number	Actual Re-Opening Date MMM DD YYYY
<input type="checkbox"/> I confirm that there has not been a breach of personal health information during the unanticipated temporary closure period; or I have taken appropriate measures to remedy any unauthorized access, use, disclosure or disposal of personal health information as soon as the breach was discovered after the unanticipated temporary closure period.		
<input type="checkbox"/> I have conducted narcotic counts and reconciliations as per PPP-65 after the pharmacy was re-opened.		
Manager Name	Registration Number	Signature
		Date MMM DD YYYY

The College collects the personal information on this application form to process the application and administer the College's related activities. The collection is authorized by the Pharmacy Operations and Drug Scheduling Act, Health Professions Act, and Freedom of Information and Protection of Privacy Act. Should you have any questions about the collection, please contact the College's Privacy Officer at 604-733-2440 or 1-800-663-1940 or privacy@bcpharmacists.org