College of Pharmacists of British Columbia

APPLICATION FOR PHARMACY CLOSURE

Form 4A

PART A: Complete Part A and submit to the College no later than 30 days before the closure date (i.e. the premises is no longer licensed) or by the deadline specified by the College.

1. INFORMATION OF CLOSING PHARMACY

Operating Name			**Pharmacy Licence Number**	
Pharmacy Address		**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Fax Number**	**Closure Date** MMM | DD | YYYY	

Reason for Closure: ☐ Permanent closure ☐ Pharmacy licence cancelled ☐ Pharmacy licence expired

PHARMACY MANAGER

Will you be returning any drugs to the manufacturer/wholesaler prior to the closure date?

☐ No, I will transfer all the drugs to the receiving pharmacy named below.

☐ Yes, I will provide the College with the documents described in section 18(2)(ee)(iii) of the *PODSA* Bylaws on/before the closure date.

☐ I have read and understand my duties and responsibilities for closing my pharmacy as described in section 18(2)(ee) of the *PODSA* Bylaws and PPP-65.

Manager Name	**Registration Number**	**Signature**	**Date** MMM | DD | YYYY

DIRECT OWNER

☐ I have read and understand my duties and responsibilities for closing my pharmacy as described in section 17.1(1) of the *PODSA* Bylaws.

Name of Authorized Representative (AR)	**Signature**	**Date** MMM | DD | YYYY

2. INFORMATION OF RECEIVING PHARMACY*

Operating Name			**Pharmacy Licence Number**	
Pharmacy Address		**City**	**Province** BC	**Postal Code**
Email Address	**Phone Number**	**Manager Name**		

Items that will be transferred to the receiving pharmacy

☐ Prescription drugs (including controlled drug substances) ☐ Medical devices

☐ Non-prescription drugs (including exempted codeine products) ☐ Patient medication records and prescription records

*If more than one receiving pharmacy is involved, complete a separate form for each receiving pharmacy to indicate the items that will be transferred to the receiving pharmacy.
*if any items will be transferred to a secure storage facility instead of a pharmacy, complete a separate form to indicate the items and provide information about the secure storage facility.

Part B: The receiving pharmacy must complete the section below and submit the form to the College within 2 weeks upon receipt of the items.

3. CONFIRMATION OF RECEIPT OF ITEMS FROM THE CLOSING PHARMACY

☐ **I have received all the items checked above on (received date): _____.**

Manager Name	**Registration Number**	**Signature**	**Date** MMM | DD | YYYY

The College collects personal information on this application form to process the application and administer the College's related activities. The collection of this information is authorized under section 26(c) of the *Freedom of Information and Protection of Privacy Act* (the Act). The College is authorized to use this information as per section 32(a) of the Act and may also disclose information in other circumstances when authorized by the Act or other legislation. Further information regarding the collection, use and disclosure of personal information can be found in the privacy policy posted on the College website: https://www.bcpharmacists.org/privacy. Should you have any questions about the collection, use or disclosure of this information, please contact our Privacy Officer at: privacy@bcpharmacists.org or 778-330-0969.