College of Pharmacists of British Columbia

APPLICATION FOR UNANTICIPATED TEMPORARY PHARMACY CLOSURE

PODSA Form 4B

PART A: CLOSURE - Complete Part A and submit a copy to the College as soon as possible.

1. INFORMATION OF PHARMACY

Operating Name	External Signage Name	Pharmacy Licence Number

Pharmacy Address	City	Province	Postal Code
		BC	

Email Address	Phone Number	Fax Number

Reason for Temporary Closure

☐ Flood/Water Damage ☐ Wildfires/Evacuation Order

☐ Earthquake ☐ Fire

☐ Structural Damage ☐ Other: _____

Temporary Closure Start Date

MMM | DD | YYYY

Anticipated Reopening 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 personal health information is securely stored during this period.

☐ I understand that should any drugs be rendered non-usable, I will destroy them appropriately and in accordance with applicable bylaws and College policies such as PPP-65.

☐ I understand that the status of my PharmaNet connection will be changed so that dispensing prescriptions will not be permitted during the closure period.

Manager Name	Registration Number	Signature	Date
			MMM | DD | YYYY

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

PART B: REOPENING - Complete Part B and submit a copy to the College no later than 5 days before the anticipated reopening date.

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

2. CONFIRMATION OF PHARMACY REOPENING

Operating Name	Pharmacy Licence Number	Anticipated Reopening Date
		MMM | DD | YYYY

☐ 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.

☐ I will conduct narcotic counts and reconciliations as soon as possible after the pharmacy is reopened as per PPP-65.

☐ I will submit a Change of Layout application if the layout of the pharmacy has been/will be changed as a result of the temporary closure.

Manager Name	Registration Number	Signature	Date
			MMM | DD | YYYY