

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 BC	Postal Code
Email Address			Phone Number	Fax Number	
Reason for Temporary Closure <input type="checkbox"/> Flood/Water Damage <input type="checkbox"/> Wildfires/Evacuation Order <input type="checkbox"/> Earthquake <input type="checkbox"/> Fire <input type="checkbox"/> Structural Damage <input type="checkbox"/> 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
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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 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
<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 will conduct narcotic counts and reconciliations as soon as possible after the pharmacy is reopened as per PPP-65 . <input type="checkbox"/> 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

The College of Pharmacists of BC ("College") collects, uses, discloses, stores, and retains personal information in compliance with the *Health Professions Act (HPA)*, the *Pharmacy Operations and Drug Scheduling Act (PODSA)*, and the *Freedom of Information and Protection of Privacy Act (FIPPA)*. The personal information you provide when completing and submitting this form is being collected and will be used by the College to carry out its mandate under the HPA in the public interest. The collection of this personal information is permitted under section 26(c) and (e) of FIPPA. If you have any questions or concerns about the College's privacy practices, please contact the College's Privacy Officer: privacy@bcpharmacists.org or 604.733.2440.