MONTANA BOARD OF PHARMACY
(301 S PARK, 4TH FLOOR, HELENA, MT 59601 - Delivery)
P. O. Box 200513
Helena, Montana 59620-0513
PHONE (406) 444-6880 FAX (406) 841-2305
E-MAIL: dlibsdpha@mt.gov WEBSITE: www.pharmacy.mt.gov

APPLICATION FOR: OUT-OF-STATE MAIL SERVICE PHARMACY

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.
(Please allow 30 days for processing from the date that the Board has a complete routine application)

BUSINESSES ARE NOT PERMITTED TO OPERATE IN MONTANA IN ANY MANNER WITHOUT AN ACTIVE MONTANA REGISTRATION

REGISTRATION REQUIREMENTS (24.174.1001-1009 ARM) Out-of-State Mail Service Pharmacies:

- No out-of-state pharmacy shall ship, mail or deliver prescription drugs and/or devices to a patient in this state unless registered by the Montana Board of Pharmacy.
- Legal entity registered and in good standing with the Montana Secretary of State information available at www.sos.mt.gov.
- If conducting online pharmacy services, registered and in good standing with the National Association of Boards of Pharmacy (NABP) Digital Pharmacy Accreditation (formerly VIPPS). For NABP accreditation information and criteria, go to: nabp.pharmacy/programs/digital-pharmacy/.
- Maintain, in readily retrievable form, records of legend drugs and/or devices dispensed to Montana patients.
- Supply upon request, all information needed by the Montana Board of Pharmacy to carry out the Board's responsibilities under the statutes and regulations pertaining to out-of-state mail service pharmacies.
- Maintain pharmacy hours that permit the timely dispensing of drugs to Montana patients and provide reasonable access for the Montana patients to consult with a licensed pharmacist about such patients' medications.
- Provide toll-free telephone communication consultation between a Montana patient and a pharmacist at the pharmacy who has access to the patient's records, and ensure that said telephone number(s) will be placed upon the label affixed to each legend drug container. Toll-free telephone service must be available at least 6 days a week and for 40 hours a week. A toll-free telephone number shall also be provided to the Board to allow for compliance with all information requests by the Board.
- Identify a pharmacist in charge of dispensing prescriptions for shipment to Montana (not required to be licensed in Montana).
- Each pharmacy that provides home infusion therapy services to Montana must be licensed with **both** the Board of Pharmacy and the Department of Public Health and Human Services (DPHHS). Information about licensing with DPHHs is available at www.dphhs.mt.gov or call (406) 444-1575.

FEES:
$240 (Non-Refundable) - Application Fee
$75 (Non-Refundable) - Montana Dangerous Drug Act Dispenser
Make check or money order payable to the Montana Board of Pharmacy

DOCUMENTS:
The following documents must be submitted to the Board office in order to complete your license application. Please make 8 ½" x 11" copies of the following and submit with your application.

- Attach a copy of your current DEA registration if applying for Dangerous Drug Dispenser Registration.
- Copy of last State Inspection.
- Copy of a Technician Utilization Plan.
- Proof of licensure with the Montana DPHHS if providing home infusion therapy services.

- Proof of registration with Montana Secretary of State. Go to "Business Services" then to "Forms" then "Business Forms" click on type of ownership or operation "Foreign" (as this business is foreign to the State of Montana) then to "Certificate of Authority".

ADDITIONAL FORMS TO BE SUBMITTED FOR AN APPLICATION TO BE COMPLETE:

- **National Practitioner Data Bank (NPDB) self-query**. This form can be obtained by calling NPDB at 800-767-6732 or visit www.npdb.hrsa.gov. This form must be mailed directly to the address indicated in the instructions. The results will come to you; upon receipt please forward them in the original sealed envelope to the Board office. Go to "Perform a Self-Query" and to "Perform a Self-Query on an Organization".
- Verification of licensure in good standing in the state in which the business is located.
- Verification of licensure in good standing of the Registered Pharmacist-in-Charge.
- If the pharmacy provides home infusion therapy services to Montana must be licensed with **both** the Board of Pharmacy and with the Department of Public Health and Human Services (DPHHS). Information about licensing with DPHHS can be obtained at www.dphhs.mt.gov or call (406)444-1575.

APPLICATION PROCEDURES:

- When the application file is complete, it will be processed and considered by Board staff for permanent registration. The applicant may be notified if additional information is required or if required to appear before the Board for an interview.
- If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-routine applications may take up to 120 days to process.
- Verification of licensure must be sent directly to the state board in which the business is located or the pharmacist-in-charge is employed. Please contact the state board prior to sending the request as some states may charge a fee for verification.
- Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PROCESSING PROCEDURES:

- Once a routine application is complete, the application takes up to 30 days to process from the time it is received in the Board office.
- The applicant will be notified in writing of any deficient or missing items from the application file.
- Once a routine application is processed and approved a permanent registration will be issued.

ADDITIONAL LAW and RULE INFORMATION:
Identification of Pharmacist-in-Charge (PIC)

- Be licensed in good standing in the state in which the out-of-state mail service pharmacy is located (PIC not required to be licensed in the State of Montana).
- Be properly listed on the application form prescribed by the Board.
- Comply with all applicable Montana laws and rules.
- Notify the Montana Board promptly of any relevant changes in employment or address, etc.
- Notify the Montana Board promptly of any disciplinary actions initiated and/or finalized against the pharmacist's license.

AGENT OF RECORD:

- Pursuant to ARM 24.174.1002 Conditions of Registration, any out-of-state mail service pharmacy must be a legal entity registered and in good standing with the Montana Secretary of State with a registered agent in Montana for service of process designated. The Certificate of Authority identifying the business entity and their Registered Agent must be submitted as part of the application. Go to www.sos.mt.gov Business Services and then Business Forms to apply for the Certificate of Authority.

PHARMACY TECHNICIANS:

- Any application for out-of-state mail service pharmacy registration from a facility located in a state which does not regulate the use of pharmacy technicians may not allow a pharmacist to supervise more than one supportive person at any one time in the compounding or dispensing of prescription drugs, unless approved by the Board.
- Any application for out-of-state mail service pharmacy licensure from a facility located in a state which does regulate the use of pharmacy technicians shall provide information on the supervisor to technician ratio allowed in the resident state, and submit a utilization plan for the employment of pharmacy technicians.

INSPECTIONS:

- If the licensing or regulatory agency of the state in which an out-of-sate mail service pharmacy is domiciled fails or refuses to inspect the out-of-state mail service pharmacy after receiving a request for an inspection from the Board of this state, the Board may cancel the out-of-state pharmacy's right to do business in this state unless the out-of-state pharmacy agrees to an onsite inspection by the Board of this state.

PRODUCT SELECTION OF PRESCRIBED DRUGS – NOTIFICATION:

- An out-of-state mail service pharmacy may not substitute a prescription drug unless the substitution is made in compliance with the laws of this state and the rules and regulations of the Board.
- An out-of-state mail service pharmacy may not dispense a substitute drug product to a resident of this state without notifying the patient of the substitution either by telephone or in writing.

COMPLIANCE:

- All statutory and regulatory requirements of the state of Montana for controlled substances, including those that are different from federal law or regulation, unless compliance would violate the pharmacy drug laws or regulations of the state in which the pharmacy is located.
- All statutory and regulatory requirements of the state of Montana regarding drug product selection laws, unless compliance would violate the laws or regulations of the state in which the pharmacy is located.
- Labeling of all prescriptions in accordance dispensed to include but not be limited to identification of the product and quantity dispensed.
- All the statutory and regulatory requirements of the state of Montana for dispensing prescriptions in accordance with the quantities indicated by the prescriber, unless compliance would violate laws or regulations of the state in which the pharmacy is located.
- Whenever a Mail Service Pharmacy changes its physical location outside of its then existing business location, its original license becomes void and must be surrendered. The Mail Service Pharmacy shall submit a new license application for the new location at least 30 days before such change occurs.
- When a Mail Service Pharmacy changes ownership, the original license becomes void and must be surrendered to the Board and a new license obtained by the new owner. The owner shall submit a new license application at least 30 days prior to the change in ownership. A change in ownership shall be deemed to occur when more than 50 percent of the equitable ownership of a business is transferred in a single transaction or in a related series of transactions to one or more persons or any other entity.
- The Board must be notified in writing when five to 50 percent of the equitable ownership of a business is transferred in a single transaction or in a related series of transactions to one or more persons or any other legal entity.

For information with regard to the processing of this application or other concerns please contact the Board of Pharmacy's staff email at dlibsdpha@mt.gov or visit the website at: www.pharmacy.mt.gov.

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES ON www.pharmacy.mt.gov

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Application for: Out-of-State Mail Order Pharmacy

☐ **New Application** ☐ **Location/Ownership Change Application**

1. Pharmacy Name: _____
2. Address: _____

   City: _____ State: _____ Zip Code: _____
3. Email Address _____
4. Resident State License Number _____ DEA Number _____
5. Telephone Number: _____ Fax: _____ Tax ID #: _____

   Toll-Free Telephone Number: _____ Fax: _____
6. Please list LICENSE NUMBER AND NAME OF BUSINESS if currently or previously licensed in Montana

   _____

   IF CURRENTLY LICENSED INDICATE REASON FOR CLOSURE: Please note with a location/ownership change a new license number will be issued and the old license number will be terminated.

   ☐ Location ☐ Ownership ☐ Other _____

   Date to Close/Terminate existing license: _____
7. Name of Registered Pharmacist-in-Charge of Dispensing to Montana

   _____

   _____ State License #_____
   (State in which the pharmacist is licensed and practicing)
8. Has the above pharmacist read the Statutes and Rules pertaining to the Montana Board of Pharmacy?
   ☐YES ☐ No
9. Describe the scope and type of services to be provided by this pharmacy

10. Does this pharmacy conduct online pharmacy services? ☐ Yes ☐ No
11. If yes, the name under which the NABP Digital Pharmacy Accreditation (formerly VIPPS) is listed:
    _____

12. Check the type of ownership or operation and attach the required information

☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Other _____

13. Check the types of drugs dispensed

☐ Controlled Substances ☐ Non-Controlled Prescription Drugs/Devices

14. Will Home Infusion Therapy be provided? ☐ Yes ☐ No

15. If, yes, proof of licensure the Montana Department of Health and Human Services (DPHHS) is required

16. Date of registration with Montana Secretary of State pursuant to ARM 24.174.1002

_____

17. Name under which business is registered with the Montana Secretary of State

_____

18. Name of Agent of Record in Montana for Service of Process

_____

19. DATE OF LAST STATE INSPECTION _____ **(Please attach copy)**

20. Indicate the method used to maintain readily retrievable records of sales of controlled substances, legend drugs and medical devices to individuals in the State of Montana

21. Are pharmacy technicians regulated in the state where the pharmacy is located? ☐ Yes ☐ No
If yes, state ratio allowed by state law _____

Please submit a copy of the pharmacy technician utilization plan.

22. Verification of licensure in good standing in the state which the business is located:

State	License #	Issue Date	Expiration Date	License Type	Requested State Verification
					☐ Yes ☐ No

23. Verification of licensure in good standing of the Pharmacist-in-Charge from the state where employed:

State	License #	Issue Date	Expiration Date	License Type	Requested State Verification
					☐ Yes ☐ No

24. Please list all state(s) where this business has an active license (include a separate sheet, if need):

PERSONAL HISTORY QUESTIONS
IMPORTANT INSTRUCTIONS AND NOTICE

1. Please read the following questions carefully. Giving an incomplete or false answer is unprofessional conduct and may result in denial of your application or revocation of your license. *See,* 37-1-105, MCA.
2. You have a continuing duty to update the information you provide in your application and supplemental responses, including while your application is pending and after you are granted a license.
3. Upon submittal of your application form, for every "yes" answer provided, you will receive a request for specific information or documents associated with the question. Your application is not complete until staff receive all information requested.
4. [Business Entities only] "You" in these instructions and questions refers to individuals authorized to answer questions on behalf of the facility, organization, or entity applying for licensure and not personally to the individuals.
5. [Business Entities with Persons in Charge] "You" in these instructions and questions refers to associates or agents of the facility, organization, or entity applying for licensure who must answer these questions personally as individuals.

PERSONAL HISTORY QUESTIONS

1. Have you ever had any license, certificate, registration, or other privilege to serve as a volunteer or practice a profession denied, revoked, suspended, or restricted by a public or private local, state, federal, tribal, religious, or foreign authority? Yes ○ No ○

2. Have you ever surrendered a credential like those listed in number 1, in connection with or to avoid action by a public or private local, state, federal, tribal, religious, or foreign authority? Yes ○ No ○

3. Have you ever resigned to avoid discipline, been suspended, or been terminated from a volunteer or employment position? Yes ○ No ○

4. Have you ever been required to participate in a behavioral modification or assistance program in lieu of suspension or termination from a volunteer or employment position? Yes ○ No ○

5. Have you ever withdrawn an application for any professional license? Yes ○ No ○

6. As of the date of this application, are you aware of any pending complaint, investigation, or disciplinary action related to any professional license you hold? Yes ○ No ○

7. Are you under a current order that remains unsatisfied (e.g., fines unpaid, probation not concluded, conditions unmet?) Yes ○ No ○

Note on Questions 8 and 9: Applicants who disclose medical, physiological, mental, or psychological conditions or chemical substance use in Question 8 or 9 may qualify for participation in the Montana Professional Assistance Program. Please visit the board website for more information about this program. "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

8. Do you have any medical, physiological, mental, or psychological condition which in any way currently (within the last 6 months) impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? Yes ○ No ○

9. Do you currently (within the last 6 months) use one or more chemical substances in any way which impairs or limits your ability to practice your profession or occupation with reasonable skill and safety? Yes ○ No ○

The following information is provided for Question 10 below:

A criminal conviction may not automatically bar you from receiving a license. For more information about how a criminal conviction may impact your application, consult the board or program website.

10. Have you ever been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or sentence deferred or suspended as an adult or “juvenile convicted as an adult” in any state, federal, tribal, or foreign jurisdiction? Yes ○ No ○

11. Are you now subject to criminal prosecution or pending criminal charges? Yes ○ No ○

12. Have you ever been disciplined, censured, expelled, denied membership or asked to resign from a professional society or organization? Yes ○ No ○

13. Have you ever had a civil judgment entered against you in a lawsuit for incompetence, negligence, or malpractice in practicing any profession? Yes ○ No ○

14. Have you ever been disqualified from working with children, elderly persons, mentally ill persons, or other vulnerable persons? Yes ○ No ○

15. Have you ever been placed on probation, restricted, reprimanded, suspended, revoked, resigned in lieu of action against you, or had other action taken against you by any hospital, clinic, health care facility, group medical practice, health maintenance organization, or third-party insurance provider, including Medicare and Medicaid? Yes ○ No ○

16. Are you currently on an exclusion list by the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services prohibiting you from working in a facility receiving federal funding? Yes ○ No ○

17. Has your authority to prescribe, dispense, or administer drugs, including controlled substances, ever been denied, restricted, suspended, or revoked? Yes ○ No ○

18. Have you ever voluntarily surrendered or had your U.S. Drug Enforcement Administration registration placed on probation, restricted, suspended, or revoked? Yes ○ No ○

I authorize the release of information concerning education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Pharmacy. I hereby declare that the information included in this application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds.

I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____

Signature of Applicant Date

PLEASE REVIEW THE MONTANA LAWS AND RULES AT www.pharmacy.mt.gov

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APPLICATION FOR: MONTANA DANGEROUS DRUG ACT REGISTRATION

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.
(Please allow 30 days for processing from the date that the Board has a complete routine application)

A BUSINESS CANNOT OPERATE IN MONTANA IN ANY MANNER WITHOUT AN ACTIVE MONTANA LICENSE

LICENSE REQUIREMENTS FOR MONTANA DANGEROUS DRUG ACT, 50-32-301 MCA, AND ARM 24.174.1401 Dangerous Drug Act

- Complete a Mail Order Pharmacy application or Montana License Number if already licensed as a Mail Order Pharmacy and adding dispensing to license
- Complete the Dangerous Drug Act application if this pharmacy will be dispensing controlled substances
- Attach a copy of your current Drug Enforcement Agency (DEA) registration

FEE: $75 – (Non-Refundable) - Dispense under the Montana Dangerous Drug Act

APPLICATION PROCEDURES:

- When the application file is complete, it will be processed. The applicant may be notified if additional information is required.
- Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PROCESSING PROCEDURES

- Once a routine application is complete, the application takes up to 30 days to process from the time it is received in the Board office.
- The applicant will be notified in writing of any deficient or missing items from the application file.
- Once a routine application is processed and approved a permanent license will be issued.

For information with regard to the processing of this application or other concerns please contact the Board of Pharmacy staff at pharmacy.mt.gov or email at dlibsdpha@mt.gov

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES AT WWW.PHARMACY.MT.GOV

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APPLICATION FOR: MONTANA DANGEROUS DRUG ACT REGISTRATION

☐ Dispense

Business Name: _____

Pharmacist-in-Charge: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

Email Address _____

DEA Registration Number: _____ Federal Tax I.D. Number: _____

Montana License Number if already licensed and adding dispensing to license _____

Signature_____ Date_____
(Signature of applicant or authorized individual)

Title _____

NOTE:
The application for DEA Number may be obtained at **www.dea.gov**
DEA will be notified when a Montana Pharmacy license has been issued

VERIFICATION OF BUSINESS LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO THE BOARD IN WHICH THE BUSINESS IS LOCATED TO OPERATE AS AN OUT-OF-STATE MAIL SERVICE PHARMACY. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD:

I am applying for a registration to operate as an Out-of-State Mail Service Pharmacy in the State of Montana. The Board of Pharmacy requires this form to be completed by the state where the business is located or the Pharmacist-in-Charge is employed. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **MT BOARD OF PHARMACY, P.O. BOX 200513, HELENA, MT 59620-0513 (DELIVERY 301 SOUTH PARK AVENUE, 4TH FLOOR HELENA, MT 59601).**
Your early response is appreciated.

_____ Name: _____
(Signature) (Please print)

Address: _____

_____

License Number is: _____

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF _____

State of: _____

Full Name of Licensee: _____

License No. _____ Issue Date: _____

License is current? _____ If NO, explain _____

Has license been suspended, revoked, placed on probation or otherwise disciplined? _____

If YES, explain and attach documentation _____

_____

Has licensee ever been requested to appear before your Board? _____

If YES, explain _____

Derogatory information, if any _____

Comments, if any _____

Signed: _____

BOARD SEAL

Title: _____

State Board: _____ Date: _____

VERIFICATION OF PHARMACIST LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO THE BOARD IN WHICH THE BUSINESS IS LOCATED TO OPERATE AS AN OUT-OF-STATE MAIL SERVICE PHARMACY. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD:

I am applying for a registration to operate as an Out-of-State Mail Service Pharmacy in the State of Montana. The Board of Pharmacy requires this form to be completed by the state where the business is located or the Pharmacist-in-Charge is employed. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **MT BOARD OF PHARMACY, P.O. BOX 200513, HELENA, MT 59620-0513 (DELIVERY 301 SOUTH PARK AVENUE, 4TH FLOOR HELENA, MT 59601).**
Your early response is appreciated.

_____ Name: _____
(Signature) (Please print)

Address: _____

_____

License Number is: _____

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF _____

State of: _____

Full Name of Licensee: _____

License No. _____ Issue Date: _____

License is current? _____ If NO, explain _____

Has license been suspended, revoked, placed on probation or otherwise disciplined? _____

If YES, explain and attach documentation _____

_____

Has licensee ever been requested to appear before your Board? _____

If YES, explain _____

Derogatory information, if any _____

Comments, if any _____

Signed: _____

BOARD SEAL

Title: _____

State Board: _____ Date: _____

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PHARMACIST-IN-CHARGE FORM

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.
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LICENSE REQUIREMENTS 24.174.1003(1)(2)(3) ARM FOR OUT-OF-STATE MAIL SERVICES PHARMACIES:

- Complete the Mail Order Pharmacy application
- Submit the Pharmacist-in-Charge form and the Non-Pharmacist-Owner agreement if owner of pharmacy is different than Pharmacist-in-Charge

ADDITIONAL RULES:

24.174.1003 Identification of Pharmacist-in-Charge of Dispensing to Montana

1) Each out-of-state mail service pharmacy that ships, mails, delivers prescription drugs and/or devices and oversees the pharmacy services provided to patients in Montana shall identify a pharmacist-in-charge of dispensing prescriptions for shipment to Montana and oversee the pharmacy services provided. Each pharmacist so identified shall meet the following requirements:
(a) be licensed in good standing in the state in which the out-of-state mail service pharmacy is located;
(b) be properly listed on the application form prescribed by the board;
(c) comply with all applicable Montana laws and rules; and
(d) notify the Montana board promptly in writing of any changes in the licensure status of the pharmacist-in-charge and any disciplinary actions initiated and/or finalized against the pharmacist's license.
(2) When the pharmacist-in-charge of an out-of-state mail service pharmacy ceases to be the pharmacist-in-charge, the pharmacist will be held responsible for notifying the board in writing of such termination of services.
(3) Within 72 hours of termination of services of the pharmacist-in-charge, a new pharmacist-in-charge must be designated in writing on the appropriate board-approved form and filed with the board.

APPLICATION PROCEDURES:

- When the application file is complete, it will be processed and considered by Board staff for permanent registration. The applicant may be notified if additional information is required or if required to appear before the Board for an interview.
- If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-routine applications may take up to 120 days to process.
- Verification of licensure must be sent directly to the state board in which the business is located or the pharmacist-in-charge is employed. Please contact the state board prior to sending the request as some states may charge a fee for verification.
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For information with regard to the processing of this application or other concerns please contact the Board of Pharmacy staff at www.pharmacy.mt.gov or email at dlibsdpha@mt.gov.

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STATEMENT OF PHARMACIST-IN-CHARGE

For the purposes of satisfying the requirements of ARM 24.174.1003(1) the following agreement has been entered into and submitted to the Montana Board of Pharmacy:

Name of Pharmacy/Business:_____ License Number: _____

Name of Pharmacist/Person-in-Charge (Please Print)
_____

Address of Pharmacy _____

City _____ State _____ Zip Code _____

Owner of Pharmacy/Business _____
(Please complete "Non-Pharmacist-Owner agreement if owner of pharmacy is different than P.I.C.)

The signature below indicates that the individual is the Pharmacist/Person-in-Charge of the above named Pharmacy/Business and will be the Pharmacist/Person-in-Charge until the present license expires: that the undersigned agrees fully and promptly to comply with the applicable federal laws, laws of the State of Montana, and the rules and regulations of the Board of Pharmacy governing this application, applicants business, and the sale of permitted drugs, pharmaceuticals, and commodities.

Signature _____ Date _____

Please retain a copy of this form in the pharmacy and send the original to the Board office

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www.pharmacy.mt.gov

PHARMACIST-IN-CHARGE AGREEMENT
(NON-PHARMACIST OWNER)

For purposes of satisfying the intent of 24.174.1003(1) the following agreement has been entered into and submitted to Montana Board of Pharmacy, PO Box 200513, Helena, MT 59620-0513:

I, _____, duly designated agent for the

_____ (pharmacy owner/corporation) do hereby vest exclusive

authority in _____, a licensed pharmacist in the State of Montana,

the State in which the out-of-state mail service pharmacy is licensed **or** person-in-charge

Pharmacist/Person-in-Charge for the _____ (name of pharmacy/business)

Pharmacy/Business License Number _____ to perform as follows:

That _____, pharmacist/person, license number _____, shall have exclusive authority to make and implement any decision which may directly or indirectly involve compliance with any of the provisions of Title 37, Chapter 7, Montana Code Annotated and Title 8, Chapter 40 of the Administrative Rules of Montana. That the parties hereto expressly agree and understand that in no event shall any person or persons, by virtue of his or their position in the corporation or for any other reason, substitute his or their judgment for that of the pharmacist/person-in-charge on matters involving the aforementioned compliance; that the parties further agree and understand that the continued right of the corporation to own and operate this pharmacy is contingent upon the existence and implementation of this agreement; and that the corporation agrees and understands that at such time as a new pharmacist/person-in-charge is designated, that a new agreement must be executed with that person and submitted to the Montana Board of Pharmacy.

Signed and dated this _____ day of _____, 20_____.

_____
Agent for the Corporation

_____
Pharmacist/Person-in-Charge

Please retain a copy of this form in the pharmacy and send the original to the Board office