| Mailing Address: | STATE BOARD OF PHARMACY<br>1-833-367-2762 | Courier Address: |
|---|---|---|
| State Board of Pharmacy<br>PO Box 2649<br>Harrisburg, PA 17105-2649 | | PA Dept of State, Bureau of Professional and Occupational Affairs<br>Attn: State Board of Pharmacy<br>2 Technology Park<br>Harrisburg, PA 17110-2919 |

# NOTICE OF CLOSURE OF A PHARMACY #854 122 (Rev 2/2023)

Board Regulation Section 27.11(f) states "A pharmacy which closes or otherwise ceases operation shall immediately return to the Board its current permit and shall immediately inform the Board of the disposition of the prescription files and nonproprietary drugs. After 30 days, neither prescription files nor nonproprietary drugs may be sold, transferred or disposed of without prior permission from the Board. When a pharmacy closes or ceases operation, signs, symbols or other indications of a pharmacy shall immediately be removed from both the interior and exterior of the premises."

**Please provide the information requested below then attach the pharmacy's original permit to this form and mail to the Board office.**

| | |
|---|---|
| **PHARMACY NAME** | |
| **PERMIT NO.** | |
| **PHARMACY ADDRESS** | |
| **CLOSURE DATE** | |
| **DISPOSITION OF THE PRESCRIPTION FILES** | |
| **DISPOSITION OF THE NON-PROPRIETARY DRUGS** | |
| **IS PHARMACY PERMIT ATTACHED?** | |

I verify that the statements in this form are true and correct to the best of my knowledge, information, and belief. I understand that false statements are made subject to the penalties of 18 PA C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate.

I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 PA C.S. Section 4911.

Signature of person completing this form:_____Date:_____

Printed name of person signing this form:_____

In the event that there are questions regarding the pharmacy's closure information, provide the following:

Contact Person's Name:_____

Contact Person's E-Mail Address:_____

Contact Person's Phone Number:_____