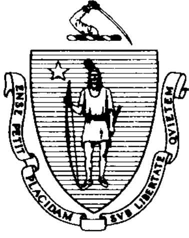


The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Board of Registration in Pharmacy
Bureau of Health Professions Licensure
239 Causeway Street, Suite 500, Boston, MA 02114

Tel: 617-973-0960
Fax: 617-973-0980
TTY : 617-973-0988
www.mass.gov/dph/boards/pharmacy

APPLICATION FOR CHANGE IN MANAGER OF A PHARMACY

Instructions:
Use this application whenever there is a change in the pharmacist Manager of Record (MOR) of a pharmacy. This application, along with any required documents, must be submitted within 10 business days upon the resignation or termination of an MOR.

Checklist of items to be submitted:

☐ A completed, signed and notarized application form.

☐ Required fee: check or money order payable to the Commonwealth of Massachusetts for $525.00

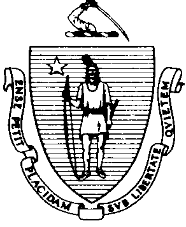
NOTE: Cash or foreign currency is not accepted. Fees are non-refundable and non-transferable.

☐ Attestation that a Controlled Substance inventory of Schedules II-V has been completed by the incoming and outgoing Managers of Record (see page 3 of the application)

The Board recommends that the Pharmacy Compliance Inspection Form be completed by the incoming Manager of Record. Please do not submit this form.
https://www.mass.gov/lists/pharmacy-practice-resources

☐ Retain a copy of the checklist, Compliance Inspection Form, completed application and all additional documents for Change in Manager of a Pharmacy for your records.

☐ For regulations pertaining to a change in MOR, please refer to Board of Pharmacy regulation 247 CMR 6.00: https://www.mass.gov/law-library/247-cmr. If additional information is needed, please contact the office at (800) 414-0168.



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BOARD USE ONLY

CHECK $________________DATE______________

CHECK NO.____________RECEIPT NO.______________________

LICENSE NO.____________________/________________________

______________________________/_______________________/____________________

APPLICATION FOR CHANGE IN MANAGER

PHARMACY LICENSE #______________________

Date the Change of Manager took place: ____

1. Legal Name of Business: ____

2. Full Business Address (Street Address, City, State and Zip): ____________________________________
____

3. Pharmacy Phone: ____
Pharmacy FAX: ___________________________Pharmacy Email: __________________________

4. All trade or business names ("D.B.A." names) used by same Corporation or by Licensee:
____

5. Has there been any change in the ownership or ownership structure of the pharmacy? ☐ Yes ☐ No

7. Name of outgoing Manager of Record (MOR)____:
____

8. License number of the outgoing MOR: ____

9. Interim Manager (if applicable)____

10. Interim Manager License No.____

11. Name of proposed MOR: ________________________

12. License number of the proposed MOR: ____

13. Has the proposed MOR met all the continuing education requirements of the MA Board of Registration in Pharmacy for the last two years? ☐ Yes ☐ No

NABP ID: ____

14. Has the proposed MOR had: (1) any convictions related to the distribution of drugs (including samples); (2) any felony convictions; (3) any suspension(s) or revocation(s) or other sanction(s) by federal, state or local governmental agency of any license or registration currently or previously held by the proposed MOR for the manufacture, distribution, or dispensing of any drugs, including controlled substances?
☐Yes ☐ No List and explain. (Attach additional sheets if necessary)

15. Have any applications for licensure been denied by any federal or state agency including any state boards of pharmacy? ☐Yes ☐No List and explain. (Attach additional sheets if necessary)

ATTESTATION OF INVENTORY OF CONTROLLED SUBSTANCES

We attest that a complete inventory of controlled substances in Schedules II through V has been completed and signed by the outgoing MOR and the proposed MOR, and filed with the pharmacy's controlled substance records. We attest that all required Schedule VI drugs have been reported to MassPat.

OUTGOING MANAGER	**PROPOSED MANAGER***
______________________________	______________________________
Print	**Print**
______________________________	______________________________
Signature	**Signature**
______________________________	______________________________
Date	**Date**

* In the event the outgoing Manager of Record is unavailable due to death, serious illness, or termination for inappropriate handling of controlled substances, a staff pharmacist may be authorized to sign the inventory, provided the Board is notified at the time the application is submitted why the staff pharmacist is signing the inventory.

Do not send a copy of the inventory to the Board. But, remember to keep a copy on file in the event it should be requested by an inspector.

AFFIDAVIT (MUST BE SIGNED AND NOTARIZED)

The applicant certifies that each person employed in any prescription drug distribution activity has the education training, and experience, or any combination thereof, sufficient for that person to perform the assigned functions in such a manner as to provide assurance that the drug product quality, safety, and security will at all times be maintained as required by law.

I hereby state that I am the person authorized to sign this application for all licensure; that all statements are true and correct in all respects and are made under the penalties of perjury.

____
Print name of duly authorized representative

____
Signature of duly authorized representative Date_____________

Sworn and subscribed before me this_________________________day of _____________________

My commission expires__________________________

____
Name of Notary Public

NOTARY SEAL

RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS.