Virginia Department of
Health Professions
Board of Pharmacy

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CLOSING OF A PHARMACY

Please provide the information requested below. (Print or Type) Use full name not initials

Name of Pharmacy		
Street Address	**Area Code and Telephone Number**	
City	**State**	**Zip Code**
Permit Number **0201-**	**Area Code and Telephone Number of Pharmacy**	
Name of Pharmacist, Owner, or Other Appropriate Contact Person	**Area Code and Telephone Number of Contact Person**	
Address of Contact Person		
Expected Closing Date (or date closed if already closed)	**Date of Notice to Public[1]**	**Date of Notice to Board[2]**
Public notice was given by[1] ☐ **sign posted at least 30 days prior to closing date** ☐ **letter to all active refills customers at least 14 days prior to closing (if letter, provide a copy to the Board with this form)**		

Disposition of Drugs and Records

(indicate the location where drugs will be transferred and records will be transferred and maintained)

Schedule II drugs:

Schedule III-V drugs:

Schedule VI drugs:

Prescription dispensing records:

Other patient information records:

Invoices and inventories:

[1] Notice must be given to the public by either the posting of a sign in a conspicuous place at least 30 days prior to closing or by mailing a notice to all active refill customers at least 14 days prior to closing. The notice must inform the public where their prescription records are to be transferred.

[2] Notice of closing must be given to the Board at least 14 days prior to closing.

For Board Use Only		
Permit Returned: ☐	**Inspector:** All drugs removed? ☐ Yes ☐ No	Signs removed? ☐ Yes ☐ No