Alberta College of Pharmacy
Pharmacy Closure

When a pharmacy closes permanently, the licensee must notify the Alberta College of Pharmacy (ACP) **immediately** of the exact date of closure. **Within five working days** of the closure, the pharmacy must submit this form to the college via email pharmacy@abpharmacy.ca.

In addition to submitting this form, the licensee must also provide ACP

- A written record of the inventory of all drugs in the pharmacy.
- A written record of all narcotic and controlled drugs transferred from the pharmacy, if applicable.

Refer to Sections 12 and 27 of the Pharmacy and Drug Regulation, for more information regarding pharmacy closures.

Section One: Closing Pharmacy Information

Date of pharmacy closure

Name of Licensee of the pharmacy — Registration #

Operating name of the pharmacy — Licence #

Physical address – PO Box # not acceptable here

City — Province — Postal code

Phone # - include area code — Fax # - include area code — Toll-free # (if applicable)

Section Two: Disposition of Drugs and Records

Part A: Drug Information

Details of the disposition of drugs from the pharmacy — **Circle your responses**

1. Drugs have been disposed of in a manner that complies with the *Controlled Drugs and Substances Act* and the *Food and Drugs Act.* If yes, _____ Name and registration number of pharmacist who witnessed destruction _____ Name and registration number of second pharmacist or regulated pharmacy technician who witnessed destruction	Yes No
2. Drugs have been returned to the wholesaler. If yes, _____ Wholesaler(s)	Yes No
3. Drugs have been transferred to another pharmacy If yes, _____ Pharmacy Name and Licence number	Yes No

4. Please describe how drugs have been disposed of other than the methods listed above:	Yes No Not Applicable
5. The option to seal drugs in a locked container or a secure area in the former pharmacy location is only permitted if approved by ACP, due to a reasonable expectation of a new licence being issued or a suspension being lifted. If you have received this approval, please indicate how the drugs will be secured to prevent unauthorized access:	Yes No Not Applicable

Pharmacist Responsible for Drugs Stored in the Former Pharmacy Location

(if approved and applicable)

I hereby acknowledge that:

❒ I will maintain the care and control of the drugs, and restrict access to the drugs, stored at the former pharmacy location as per the Standards for the Operation of Licensed Pharmacies and Standards of Practice for Pharmacists and Pharmacy Technicians.

I, _____

Full name ACP Registration number

_____ _____

Signature Date

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Part B: Patient Record Information

Details of how patients may access their records

Circle your responses

6. Patient records have been transferred to another pharmacy. If yes, indicate the name and licence number of the pharmacy:	Yes No Not Applicable
7. Patients have been provided a copy of their records. If yes, indicate in which form (electronic, paper copies etc.):	Yes No Not Applicable
8. Patients have been notified of the pharmacy closure and the location of their pharmacy records via the following means: ❒ Displaying signs on all exits/entrances to the premises ❒ Updating websites ❒ Updating voicemail greetings on phone ❒ Bag stuffers ❒ Media Other (please describe):	

Storage of patient records

Circle your responses

9. Patient records will be stored at another pharmacy. If yes, provide the name and licence number of the pharmacy:	Yes No Not Applicable
10. Patient records will be stored at a location that is not a pharmacy. If yes, provide the name/details of the storage facility:	Yes No Not Applicable
If yes to 10, complete questions a) to f): a) Address of the storage facility:	

b) If the storage location is not a formal records management or secure storage facility, provide a description of where the records will be housed:

c) Name, title, and contact information for person(s) who own, lease or control (manage) the building or the portion of the building where records will be stored:

Contact name	Title	Phone number	Email address
Contact name	Title	Phone number	Email address
Contact name	Title	Phone number	Email address

d) List any other individuals who are involved in accessing/storing the records at this location (include the person's name and relation to the pharmacy):

Contact name (Relation to the pharmacy)	Title	Phone number	Email address
Contact name (Relation to the pharmacy)	Title	Phone number	Email address
Contact name (Relation to the pharmacy)	Title	Phone number	Email address

e) List the types of records that will be stored at the record storage location:

❒ electronic records ❒ computer server ❒ prescription hard copy
❒ records of care ❒ drug records
❒ other

f) Please explain what procedures and/or agreements are in place to ensure that care and control of the records will be maintained, the records will be secured, access to the records will be restricted and controlled, and the requirements of the Standards for Operation of Licensed Pharmacies and the Standards of Practice for Pharmacists and Pharmacy Technicians will be complied with, as assured by the former licensee or pharmacist:

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Pharmacy Closure

Pharmacist Responsible for Storage of Patient Records

(if applicable)

I **hereby acknowledge that:**

❒ I will maintain the care and control of the records stored at the above listed facility
❒ I will restrict and control access to the records stored at the above listed facility
❒ I will ensure the requirements of the Standards for Operating Licensed Pharmacies are met in regard to the above records

I, _____

Full name ACP Registration number

_____ _____

Signature Date

Section Three: Pharmacist and Proprietor Information

Pharmacist Performing the Closure

I am the licensee of the closing pharmacy: ❒ Yes ❒ No
If no, what is my role at the pharmacy: _____

I declare that all the information provided in this form regarding the permanent closure of the pharmacy is true to the best of my knowledge.

I, _____

Full name ACP Registration number

_____ _____

Signature Date

Proprietor's Agent Performing the Closure

I am the proprietor's agent of the closing pharmacy: ❒ Yes ❒ No
If no, what is my role at the pharmacy: _____

I hereby acknowledge that:

❒ I have taken reasonable steps to ensure that records are maintained in accordance with the legislation.
❒ I will provide any assistance required by the pharmacist, responsible for the patient records, in respect of carrying out their duties.
❒ I will provide the pharmacist, responsible for the patient records, any records that are in the possession or under the control of the proprietor, if those records are requested by the pharmacist.

I declare that all the information provided in this form regarding the permanent closure of the pharmacy is true to the best of my knowledge.

I, _____

Full name

_____ _____

Signature Date