

CHANGE OF EMPLOYMENT NOTICE

FORM # 0411

- ❶ Complete the form then hand sign and date. ❷ Make a copy for your file. **TYPE OR PRINT LEGIBLY**
❸ Mail or fax the original to the Board office.

I HEREBY GIVE NOTICE, AS REQUIRED BY RULE 4729-5-06 OF THE OHIO ADMINISTRATIVE CODE, THAT MY PLACE OF EMPLOYMENT HAS CHANGED AS FOLLOWS:

FORMER PLACE OF EMPLOYMENT

Name of Former Employer:	Ohio Drug Distributor License No.:	END DATE of Employment:
<u>Attention Responsible Pharmacists:</u> Rule 4729-5-11 provides that the <u>pharmacist whose name appears on the terminal distributor of dangerous drugs license shall be in charge</u> of the practice of the profession of pharmacy in the prescription department including, but not limited to, maintaining all drug records required by state or federal law. Rule 4729-5-11(C) requires that <u>if there is a change</u> in the responsible pharmacist, the Board shall be notified on a Board-approved form by certified mail, return receipt requested, or by <u>verified</u> facsimile transmission within thirty days thereof of the effective date of the change and the name of the new responsible pharmacist. Those pharmacists failing to notify the Board that they are no longer the responsible pharmacist will be held <u>responsible until the Board has been so notified</u> .		

NEW PLACE OF EMPLOYMENT

Attention Interns: Do not use this form. Do file a Statement of Preceptor form.

Name of New Employer:		Ohio Drug Distributor License No.:
Street Address:		START DATE of Employment:
City, State, Zip Code:		County:
Area Code / Telephone Number:	Area Code / Fax Number:	E-mail Address: (Do NOT return this form by e-mail)

NAME AND IDENTIFICATION

Full Name:	Ohio Pharmacist I.D. Number:
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I HEREBY REQUEST ALL STATE BOARD OF PHARMACY RECORDS BE CHANGED TO REFLECT MY NEW PLACE OF EMPLOYMENT AS I HAVE INDICATED ABOVE.

SIGNATURE

DATE SIGNED