



PHARMACIST CHANGE OF EMPLOYMENT NOTICE

Complete form then sign and date. Make a copy for your file, mail, e-mail or fax the original to the Board office. Type or print legibly.

I HEREBY GIVE NOTICE, AS REQUIRED BY OAC 4729-5-06, THAT MY PLACE OF EMPLOYMENT HAS CHANGED AS FOLLOWS:

FORMER PLACE OF EMPLOYMENT

Name of Former Employer	Ohio DDD License#	END DATE of Employment
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Attention Responsible Pharmacists

Rule 4729-5-11 provides that the pharmacist whose name appears on the terminal distributor of dangerous drugs license shall be in charge 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 if there is a change in the responsible pharmacist, the Board shall be notified on a Board-approved form by certified mail, return receipt requested, or by verified facsimile transmission within thirty days 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 responsible until the Board has been so notified. Please see *Terminal Distributor Change of Responsible Person Notice* located on our website.

NEW PLACE OF EMPLOYMENT

Attention Interns: Do not use this form. Instead, use the Statement of Preceptor form.

Name of New Employer		Ohio DDD License#
Street Address		START DATE of Employment
City, State, Zip Code		County:
Area Code / Phone#	Area Code / Fax#	E-mail Address (Do NOT return this form by e-mail)

NAME AND IDENTIFICATION

Pharmacist Full Name	Ohio Pharmacist ID#
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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.

PHARMACIST SIGNATURE

DATE SIGNED

77 South High Street, 17th Floor, Columbus, Ohio 43215

