



# TEXAS STATE BOARD OF PHARMACY

1801 Congress Ave, Ste. 13.100 ★ Austin, Texas 78701

512-305-8029 ★ [www.pharmacy.texas.gov](http://www.pharmacy.texas.gov)

## Temporary Pharmacy Closing Notification for Loss of Pharmacist-In-Charge

Complete this notification form in full. See Texas Pharmacy Rule §291.3 regarding required notifications, as well as 291.5 for Emergency or temporary closing; a pharmacy may not temporarily close for a period that **exceeds 30 days**. If the pharmacy experiences a loss of a Pharmacist-in-Charge, the pharmacy will need to comply with Texas Pharmacy Rule [§291.5\(d\)](#) and notify the Board when the pharmacy has re-opened and resumes regular pharmacy business.

Print or Type

### Pharmacy Information

Pharmacy Name: \_\_\_\_\_ Pharmacy License Number: \_\_\_\_\_

*Pharmacy Name (Doing Business As)*

Date of Temporary Closing: \_\_\_\_\_

Date of Anticipated Re-Opening: \_\_\_\_\_

Address: \_\_\_\_\_  
*Pharmacy Street Address* *Suite/Unit #*

\_\_\_\_\_  
*City* *State* *Zip Code*

### Designated Person of Contact for Pharmacy

Full Name: \_\_\_\_\_ Title: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_ Contact E-Mail: \_\_\_\_\_

Name of Departing Pharmacist-In-Charge: \_\_\_\_\_ Date of Departure: \_\_\_\_\_

### Emergency or Temporary Closing Reason

Reason for Temporarily Closing \_\_\_\_\_

Provide a description of how the pharmacy's drugs and records are secured while the pharmacy is temporarily closed: (attach additional page, if necessary.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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## Attestation and Signature

**Attest:** *I hereby attest that by submitting this form, the above-mentioned pharmacy will be closed temporarily, and the foregoing statements on this form and those on any attachment(s) to this form are to the best of my knowledge true and correct and that they are given of my free will. I agree that any misstatement(s) or omission(s) as to material facts will constitute violation of and subject me to the penalties set forth in the Texas Pharmacy Act and Rules. I agree to comply with the Texas Pharmacy Act and Rules.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

**E-MAIL to:** [Compliance.General@Pharmacy.Texas.Gov](mailto:Compliance.General@Pharmacy.Texas.Gov)

Or submit by **MAIL** to:

Texas State Board of Pharmacy  
c/o Compliance Division  
1801 Congress Ave., Ste. 13.100  
Austin, TX 78701