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)

Name of Pharmacy		
Street Address	**Telephone Number**	
City	**State**	**Zip Code**
Permit Number 0201-	**Email Address of Contact Person**	
Name of Pharmacist, Owner, or Other Appropriate Contact Person	**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] The notice must inform the public where their prescription records are to be transferred.
[2] Notice of closing must be received by the Board at least 14 days prior to closing.

For Board Use Only		
Permit Returned: ☐	Open Investigations? ☐ Yes ☐ No	Signs removed? ☐ Yes ☐ No