Virginia Department of Health Professions Board of Pharmacy	9960 Mayland Drive, Suite 300 Henrico, Virginia 23233 (804) 367-4456 (Tel) (804) 527-4472 (Fax) pharmbd@dhp.virginia.gov www.dhp.virginia.gov/pharmacy

APPLICATION FOR APPROVAL OF AN INNOVATIVE (PILOT) PROGRAM

☐	Application Fee:	$325.00
☐	Renewal	Call Board for fee
☐	Change of Responsible Pharmacist	$35

The required non-refundable fee must accompany the application. Make check payable to "Treasurer of Virginia".

Applicant—Please provide the information requested below. (Print or Type) Use full name not initials

Title of Pilot Program		
Name of Pharmacy where pilot program is to be conducted*	Pharmacy Permit Number 0201-	
Street Address	Area Code and Telephone Number	
City	State	Zip Code
Name of Virginia Licensed Pharmacist Responsible for Pilot Program **	Virginia License Number of Pharmacist Responsible for Pilot Program	
Contact phone number	Email address	

For Board Use Only			
Date Received	Date of IFC	Pending Number	Program Number Assigned
Renewal Date	Termination Date		

*If requesting that the pilot program be conducted at more than one pharmacy, provide a list of additional pharmacies and responsible pharmacists as Attachment 8.

**Responsible pharmacist need not be the PIC of the pharmacy, but should be the pharmacist who will most closely oversee and supervise the operation of the pilot program.

Please attach the following additional information and label as indicated. Please write this in lay terms that may be easily understood by non-pharmacists and persons not familiar with computers or other technology to be used in the practice of pharmacy:

LABEL	DESCRIPTION
Attachment 1:	A brief description, narrative, or summary of the new process or procedure for which approval is being sought.
Attachment 2:	A listing of the laws or regulations for which waivers are being requested through approval of this program and a brief explanation why each waiver is needed.
Attachment 3:	An explanation as to the rationale for the program, i.e. benefit to the consumer or industry.
Attachment 4:	A summary of the outcomes that will be measured, method for measuring, and timelines for measurements, including requested duration of the approval.
Attachment 5:	Any measures that will be taken to ensure security of drug product and confidential information in the execution of the pilot program, if applicable.
Attachment 6:	Disclosure of any financial interests, if applicable.
Attachment 7:	Any additional supporting information, such as technical or other descriptive literature describing equipment or a process, or information from another state where this process or procedure has been tested, etc.
Attachment 8:	List of any additional pharmacies, permit number, corresponding responsible pharmacists and their license numbers if requesting that the pilot program be conducted at multiple sites.

I attest that the information furnished on this application is true and correct to the best of my knowledge.

Signature of Applicant ______________________________

Date ______________________________