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| **\*** \*Thi Note: This form is not applicable where a pharmacy is relocating to a new location. |
| **1. Pharmacy details** |
| Name: |       | Telephone: |       |
| Address: |       |
| Suburb: |       | Postcode: |       |
| Planned date of pharmacy closure: |       |

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| **2. Contact details for pharmacy owner (individual, partnership or proprietary owner) after closure** |
| Name: |       |
| (Individual owner or nominated person to contact where partnership or proprietary owner) |
| Phone/Mobile: |       |
| Email address: |       |

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| **3. Storage location of Schedule 4 and Schedule 8 records** |
| This includes original dispensed prescriptions and repeats, any electronic copies of prescriptions, electronic or hard copy dispensing records, copies of stock orders and invoices and Schedule 8 registers |
| Address:  |       |
| Suburb: |       | Postcode: |       |

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| **4. Transfer location of Schedule 4 and Schedule 8 medicines** |
| Will the pharmacy that is closing be transferring any stock to another pharmacy?  | Yes | [ ]  | No | [ ]  |
| Note: routine transfer of scheduled medicines between pharmacies is not allowed. |
| If **yes**, complete details for the receiving pharmacy below.  |
| Pharmacy name: |       |
| Address: |       |
| Suburb: |       | Postcode: |       |
| If **no**, describe how any remaining stock of scheduled medicines will be safely disposed of when the pharmacy closes: |
|       |
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| **5. List of Schedule 8 medicines transferred** |
| Complete this section if the closing pharmacy will be transferring Schedule 8 medicines to another pharmacy. |
| Name of medicine | Strength | Form | Quantity |
|       |       |       |       |
|       |       |       |       |
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|       |       |       |       |
| If there is insufficient space, please attach extra pages to this form. |
| **6. Details of pharmacist with overall responsibility at time of closure** |
| Name: |       |
| AHPRA registration number: |       |
| Phone/Mobile: |       |
| Email address: |       |
| Signature: |       | Date: |       |

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| **7. Checklist** |
| [ ]  | Arranged transfer of any remaining repeats for Schedule 8 medicines to another pharmacy. [Application form (Word 810KB)](https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/medicines%20and%20poisons/Word/Application-Inter-pharmacy-transfer-of-Schedule-8-prescription.doc). |
| [ ]  | Submitted a final Schedule 8 and CPOP report to the Department for the period from the last monthly report to the date of closure, as well as any previous outstanding reports. |
| [ ]  | Advised the Pharmacy Registration Board of Western Australia of the intention to close at least 14 days before the planned date of closure. |
| [ ]  | * Advised the Community Pharmacotherapy Program of the intention to close at least one month prior to closure (for pharmacies authorised to dispense opioid substitution therapy only)
 |
| [ ]  | Notified other local healthcare providers and pharmacies in nearby towns of the impending closure (for rural pharmacies only). |