



THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

New York State Board of Pharmacy
Tel. (518) 474-3817ext130 Fax (518) 473-6995 E-mail: pharombd@nysed.gov

CHANGE OF SUPERVISING PHARMACIST OUTSOURCING FACILITY

Name of Registered Establishment: _____

Address of Establishment: _____

Registration Number: _____ Telephone Number: _____

APPLICANT'S AFFIDAVIT

I, _____ do hereby certify that I replaced
Print Name

_____ as supervisor of the above named establishment on

_____ ; and that I am employed for _____ hours per week at the above
month/day/year

location.

I further certify that I have full knowledge of my professional responsibilities and I have reviewed:

1. "Responsibilities of a Supervisor" issued by the Board of Pharmacy
2. Title 21, Code of Federal Regulations
3. Regulations pertaining to specialized activities, including compounding of sterile materials.

I am a pharmacist licensed in New York State.

New York State license number: _____ Date of license: _____ / _____ / _____
mo. day yr.

New York State registration expiration date: : _____ / _____ / _____ Date of Birth: : _____ / _____ / _____
mo. day yr. mo. day yr.

Supervising Pharmacist signature

Date

Print Name

Corporate Officer's signature and date (Indicate title)

Print Name

E-mail Address

**Return Directly to: The New York State Education Department, Office of the Professions, State Board of
Pharmacy, 89 Washington Avenue, Albany, NY 12234**

OF 105, July 2014