

MONTANA BOARD OF PHARMACY
(301 S PARK, 4TH FLOOR, HELENA, MT 59601 - Delivery)
P. O. Box 200513
Helena, Montana 59620-0513
PHONE (406) 841-2203 FAX (406) 841-2344
E-MAIL: dlibsdpba@mt.gov WEBSITE: pharmacy.mt.gov

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.

(Please allow 30 days for processing from the date that the Board has a complete routine application)

BUSINESSES ARE NOT PERMITTED TO OPERATE IN MONTANA IN ANY MANNER WITHOUT AN ACTIVE MONTANA REGISTRATION

REGISTRATION REQUIREMENTS (24.174.1001-1009 ARM) Out-of-State Mail Service Pharmacies:

No out-of-state pharmacy shall ship, mail or deliver prescription drugs and/or devices to a patient in this state unless registered by the Montana Board of Pharmacy

Legal entity registered and in good standing with the Montana Secretary of State information available at www.sos.mt.gov

Registered and in good standing with the National Association of Boards of Pharmacy Verified Internet Pharmacy Practice Sites (VIPPS) if registered after June 1, 2001

Maintain, in readily retrievable form, records of legend drugs and/or devices dispensed to Montana patients

Supply upon request, all information needed by the Montana Board of Pharmacy to carry out the Board's responsibilities under the statutes and regulations pertaining to out-of-state mail service pharmacies

Maintain pharmacy hours that permit the timely dispensing of drugs to Montana patients and provide reasonable access for the Montana patients to consult with a licensed pharmacist about such patients' medications

Provide toll-free telephone communication consultation between a Montana patient and a pharmacist at the pharmacy who has access to the patient's records, and ensure that said telephone number(s) will be placed upon the label affixed to each legend drug container. Toll-free telephone service must be available at least 6 days a week and for 40 hours a week. A toll-free telephone number shall also be provided to the Board to allow for compliance with all information requests by the Board

Identify a pharmacist in charge of dispensing prescriptions for shipment to Montana (not required to be licensed in Montana)

Each pharmacy that provides home infusion therapy services to Montana must be licensed with **both** the Board of Pharmacy and the Department of Public Health and Human Services (DPHHS). Information about licensing with DPHHS can be obtained at www.dphhs.mt.gov or by calling (406) 444-1575

FEES: **\$400 (Non-Refundable) - Application Fee**
 \$ 75 (Non-Refundable) - Montana Dangerous Drug Act Dispenser Fee
 Make check or money order payable to the Montana Board of Pharmacy

DOCUMENTS: The following documents must be submitted to the Board office in order to complete your license application. Please make 8 ½" x 11" copies of the following and submit with your application.

Attach a copy of your current DEA registration if applying for Dangerous Drug Dispenser Registration
Copy of last State Inspection

Proof of registration with Montana Secretary of State. Go to "Business Services" then to "Forms" then "Business Forms" click on type of ownership or operation "Foreign" (as this business is foreign to the State of Montana) then to "Certificate of Authority"

Proof of licensure with the Montana DPHHS if providing home infusion therapy services
Copy of a Technician Utilization Plan

ADDITIONAL FORMS TO BE SUBMITTED FOR AN APPLICATION TO BE COMPLETE:

National Practitioner Data Bank (NPDB) self-query . This form can be obtained by calling NPDB at 800-767-6732 or visit www.npdb-hipdb.com on the Internet. This form must be mailed directly to the address indicated in the instructions. The results will come to you; upon receipt please forward them to the Board office. Go to "Perform a Self-Query" and to "Perform a Self-Query on an Organization"

Verification of licensure in good standing in the state in which the business is located

Verification of licensure in good standing of the Registered Pharmacist-in-Charge

If the pharmacy provides home infusion therapy services to Montana must be licensed with **both** the Board of Pharmacy and with the Department of Health and Human Services (DPHHS).

Information about licensing with DPHHS can be obtained at www.dphhs.mt.gov or by calling (406)444-1575

APPLICATION PROCEDURES:

When the application file is complete, it will be processed and considered by Board staff for permanent registration. The applicant may be notified if additional information is required or if required to appear before the Board for an interview.

If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-routine applications may take up to 120 days to process. Verification of licensure must be sent directly to the state board in which the business is located or the pharmacist-in-charge is employed. Please contact the state board prior to sending the request as some states may charge a fee for verification.

Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PROCESSING PROCEDURES:

Once a routine application is complete, the application takes up to 30 days to process from the time it is received in the Board office.

The applicant will be notified in writing of any deficient or missing items from the application file.

Once a routine application is processed and approved a permanent registration will be issued.

ADDITIONAL LAW and RULE INFORMATION:

Identification of Pharmacist-in-Charge (PIC)

Be licensed in good standing in the state in which the out-of-state mail service pharmacy is located (PIC not required to be licensed in the State of Montana)

Be properly listed on the application form prescribed by the Board

Comply with all applicable Montana laws and rules

Notify the Montana Board promptly of any relevant changes in employment or address, etc.

Notify the Montana Board promptly of any disciplinary actions initiated and/or finalized against the pharmacist's license

Agent of Record:

Any such out-of-state mail service pharmacy that does not so designate a resident agent and that ships, mails or delivers prescription drugs and/or devices in the state of Montana shall be deemed an appointment by such out-of state mail service pharmacy of the Secretary of State to be its true

and lawful attorney, upon whom may be served all legal process in any action or proceeding against such pharmacy growing out of or arising from such delivery

A copy of any such service of process shall be mailed to the out-of-state mail service pharmacy by the complaining party by certified mail, return receipt requested, postage prepaid, at the address of such out-of-state mail service pharmacy as designated on the pharmacy's application for registration in this state.

If any such pharmacy is not registered in this state, service on the Secretary of State of Montana only shall be sufficient service

PHARMACY TECHNICIANS:

Any application for out-of-state mail service pharmacy registration from a facility located in a state which does not regulate the use of pharmacy technicians may not allow a pharmacist to supervise more than one supportive person at any one time in the compounding or dispensing of prescription drugs, unless approved by the Board

Any application for out-of-state mail service pharmacy licensure from a facility located in a state which does regulate the use of pharmacy technicians shall provide information on the supervisor to technician ratio allowed in the resident state, and submit a utilization plan for the employment of pharmacy technicians

INSPECTIONS:

If the licensing or regulatory agency of the state in which an out-of-state mail service pharmacy is domiciled fails or refuses to inspect the out-of-state mail service pharmacy after receiving a request for an inspection from the Board of this state, the Board may cancel the out-of-state pharmacy's right to do business in this state unless the out-of-state pharmacy agrees to an onsite inspection by the Board of this state

PRODUCT SELECTION OF PRESCRIBED DRUGS – NOTIFICATION:

An out-of-state mail service pharmacy may not substitute a prescription drug unless the substitution is made in compliance with the laws of this state and the rules and regulations of the Board

An out-of-state mail service pharmacy may not dispense a substitute drug product to a resident of this state without notifying the patient of the substitution either by telephone or in writing

COMPLIANCE:

All statutory and regulatory requirements of the state of Montana for controlled substances, including those that are different from federal law or regulation, unless compliance would violate the pharmacy drug laws or regulations of the state in which the pharmacy is located

All statutory and regulatory requirements of the state of Montana regarding drug product selection laws, unless compliance would violate the laws or regulations of the state in which the pharmacy is located

Labeling of all prescriptions in accordance dispensed to include but not be limited to identification of the product and quantity dispensed

All the statutory and regulatory requirements of the state of Montana for dispensing prescriptions in accordance with the quantities indicated by the prescriber, unless compliance would violate laws or regulations of the state in which the pharmacy is located

Whenever a Mail Service Pharmacy changes its physical location outside of its then existing business location, its original license becomes void and must be surrendered. The Mail Service Pharmacy shall submit a new license application for the new location at least 30 days before such change occurs

When a Mail Service Pharmacy changes ownership, the original license becomes void and must be surrendered to the Board and a new license obtained by the new owner. The owner shall submit a new license application at least 30 days prior to the change in ownership. A change in ownership shall be deemed to occur when more than 50 percent of the equitable ownership of a business is

transferred in a single transaction or in a related series of transactions to one or more persons or any other entity.

The Board must be notified in writing when five to 50 percent of the equitable ownership of a business is transferred in a single transaction or in a related series of transactions to one or more persons or any other legal entity

For information with regard to the processing of this application or other concerns please contact the Board of Pharmacy's staff email at dlibspha@mt.gov or visit the website at: pharmacy.mt.gov

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES ON THE WEBSITE

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Application for Registration as Out-of State Mail Service Pharmacy:

1. Pharmacy Name: _____
2. Address: _____
City: _____ State: _____ Zip Code: _____
3. Email Address _____
4. Resident State License Number _____ DEA Number _____
5. Telephone Number: _____ Fax : _____ Tax ID #: _____
Toll-Free Telephone Number: _____ Fax: _____
6. Please list license number and name of business if previously licensed in Montana and the approximate date of closure for this license

Reason for Closure:
 Location Ownership Other _____
7. Name of Registered Pharmacist-in-Charge of Dispensing to Montana

State License # _____
(State in which the pharmacist is licensed and practicing)
8. Has the above pharmacist read the Statutes and Rules pertaining to the Montana Board of Pharmacy?
 YES No
9. Describe the scope and type of services to be provided by this pharmacy
10. Does this pharmacy intend to be accessible on-line Yes No
11. If yes, the name under which the VIPPS Certification is listed

12. Check the type of ownership or operation and attach the required information+
 Sole Proprietor Partnership Corporation Other _____

13. Check the types of drugs dispensed
 Controlled Substances Non-Controlled Prescription Drugs/Devices
14. Will Home Infusion Therapy be provided? Yes No
15. If, yes, proof of licensure the Montana Department of Health and Human Services (DPHHS) is required
16. Date of registration with Montana Secretary of State pursuant to ARM 24.174.1002

17. Name under which business is registered with the Montana Secretary of State

18. Name of Agent of Record in Montana for Service of Process

19. DATE OF LAST STATE INSPECTION _____ **(Please attach copy)**

20. Indicate the method used to maintain readily retrievable records of sales of controlled substances, legend drugs and medical devices to individuals in the State of Montana

21. Are pharmacy technicians regulated in the state where the pharmacy is located? Yes No
 If yes, state ratio allowed by state law _____
 Please submit a copy of the pharmacy technician utilization plan

22. Verification of licensure in good standing in the state which the business is located:

State	License #	Issue Date	Expiration Date	License Type	Requested State Verification
					<input type="checkbox"/> Yes <input type="checkbox"/> No

23. Verification of licensure in good standing of the Pharmacist-in-Charge from the state where employed:

State	License #	Issue Date	Expiration Date	License Type	Requested State Verification
					<input type="checkbox"/> Yes <input type="checkbox"/> No

24. Please list all state(s) where this business has an active license (include a separate sheet, if need):

25. Has this business or the person in charge of this business who is listed on the application ever had an application for a professional or occupational license refused or denied? If yes, please attach a detailed explanation and provide supporting documentation from the source. Yes No

26. Has this business or the person in charge of this business who is listed on the application ever withdrawn an application for licensure prior to the licensing agency's decision regarding your application? If yes, please attach a detailed explanation

and provide supporting documentation from the source.

Yes No

27. Has the person in charge of this business who is listed on this application ever been denied the privilege of taking an examination required for any professional or occupational license? If yes, please attach a detailed explanation and provide supporting documentation from the source.

Yes No

28. Has the person in charge of this business who is listed on this application ever withdrawn or been suspended, placed on probation, expelled or requested to resign from any postsecondary educational program? If yes, please attach a detailed explanation and provide supporting documentation from the source.

Yes No

29. Has the person in charge of this business who is listed on this application ever requested temporary or permanent leave of absence, been placed on probation, restricted, suspended, revoked, allowed to resign, or otherwise acted against by any professional or occupational education program (i.e., residency, internship, apprenticeship, etc)? If yes, please attach a detailed explanation and provide supporting documentation from the source.

Yes No

30. Has a licensing agency initiated or completed disciplinary action against this business or the person in charge of this business who is listed on this application? If yes, please provide agency documents including the complaint, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements directly from the source.

Yes No

31. Has this business or the person in charge of this business who is listed on this application voluntarily surrendered, cancelled, forfeited, failed to renew a professional or occupational license in anticipation of or during an investigation or disciplinary proceeding or action? If yes, please attach a detailed explanation and provide supporting documentation from the source.

Yes No

32. Has a complaint ever been made against this business or person in charge of this business who is listed on this application with a professional or occupational licensing agency? If yes, please attach a detailed explanation and provide supporting documentation from the source.

Yes No

33. Has this business or the person in charge of this business who is listed on this application ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding hospital, facility or staff privileges; health maintenance organization participation, third party provider or Medicare/Medicaid participation; or any other privileges? If yes, please attach a detailed explanation and provide supporting documentation from the source.

Yes No

34. Has this business or the person in charge of this business who is listed on this application ever been censured, expelled, denied membership or asked to resign from a professional organization related to the profession or occupation? If yes, please attach a detailed explanation and provide documentation from the source.

Yes No

35. Has this business or the person in charge of this business who is listed on this application ever been the subject of any sanction or action, denial, suspension, revocation, restriction or termination regarding the ability to prescribe, dispense or administer drugs including controlled substances? If yes, please attach a detailed explanation and provide documentation from the source.

Yes No

36. Does this business or the person in charge of this business who is listed on this application have any initiated or completed action against you by any state, federal, tribal, or foreign licensing jurisdiction? (For example: Drug Enforcement Agency; Alcohol, Tobacco and Firearms; Homeland Security; Indian Health Service, etc) If yes, please attach a

Detailed explanation and provide documentation from the source.

Yes No

37. Have any civil legal proceedings been filed against this business or the person in charge of this business who is listed on this application by a (patient/client), (former patient/client) or employer/employee? If yes, attach a detailed explanation and documentation from the source including initiating document(s) and documentation of final disposition.

Yes No

38. Does this business or the person in charge of this business who is listed on the application ever been convicted of a misdemeanor or felony crime or have a pending criminal charge? "Convicted" for the purposes of this question includes a conviction under appeal, guilty plea, no contest plea, and/or forfeiture of bond. "A pending criminal charge" for the purposes of this question includes a deferred imposition of sentence and/or deferred prosecution. If answered yes, a detailed explanation must be submitted on the events AND the charging documents and final judgments or orders of dismissal. You must report but may omit documentation for: (1) misdemeanor traffic violations older than 10 years ago and that resulted in fines of less than \$200; and (2) convictions prior to your 18th birthday unless you were tried as an adult.

Yes No

39. Has the person in charge of this business who is listed on this application ever been diagnosed with chemical dependency or another addiction, or participated in a chemical dependency or other addiction treatment program? If yes, please attach a detailed explanation and provide documentation regarding evaluations, diagnosis, treatment recommendations and monitoring from the source.

Yes No

40. Has the person in charge of this business who is listed on this application ever been diagnosed with a physical condition or mental health disorder involving potential health risk to the public? If yes, please provide a detailed explanation.

Yes No

41. Has the person in charge of this business who is listed on this application ever been court-martialled or discharged other than honorably from any branch of the armed service? If yes, attach a detailed explanation and documentation for the source.

Yes No

I authorize the release of information concerning education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Pharmacy. I hereby declare that the information included in this application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds.

Signature of Applicant

Date

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LICENSE REQUIREMENTS FOR MONTANA DANGEROUS DRUG ACT
50-32-301 MCA

24.174.1401 Dangerous Drug Act

Complete a Mail Order Pharmacy application or Montana License Number if already licensed as a Mail Order Pharmacy and adding dispensing to license

Complete the Dangerous Drug Act application if this pharmacy will be dispensing controlled substances

Attach a copy of your current Drug Enforcement Agency (DEA) registration

FEE: \$75 – (Non-Refundable) - Dispense under the Montana Dangerous Drug Act

APPLICATION PROCEDURES:

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PROCESSING PROCEDURES

Once a routine application is complete, the application takes up to 30 days to process from the time it is received in the Board office.

The applicant will be notified in writing of any deficient or missing items from the application file. Once a routine application is processed and approved a permanent license will be issued.

For information with regard to the processing of this application or other concerns please contact the Board of Pharmacy staff at pharmacy.mt.gov or email at dlibsdpba@mt.gov

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES ON THE WEBSITE

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APPLICATION FOR REGISTRATION UNDER THE MONTANA DANGEROUS DRUG ACT

Dispense

Business Name: _____

Pharmacist-in-Charge: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

DEA Registration Number: _____ Federal Tax I.D. Number: _____

Montana License Number if already licensed and adding dispensing to license _____

Signature _____ Date _____
(Signature of applicant or authorized individual)

Title _____

NOTE:

The application for DEA Number may be obtained at www.dea.gov
DEA will be notified when a Montana Pharmacy license has been issued

VERIFICATION OF BUSINESS LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO THE BOARD IN WHICH THE BUSINESS IS LOCATED TO OPERATE AS AN OUT-OF-STATE MAIL SERVICE PHARMACY. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD:

I am applying for a registration to operate as an Out-of-State Mail Service Pharmacy in the State of Montana. The Board of Pharmacy requires this form to be completed by the state where the business is located or the Pharmacist-in-Charge is employed. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **MT BOARD OF PHARMACY, P.O. BOX 200513, HELENA, MT 59620-0513 (DELIVERY 301 SOUTH PARK AVENUE, 4TH FLOOR HELENA, MT 59601)** Your early response is appreciated.

(Signature) Name: _____
(Please print)

Address: _____

License Number is: _____

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF _____

State of: _____

Full Name of Licensee: _____

License No. _____ Issue Date: _____

License is current? _____ If NO, explain _____

Has license been suspended, revoked, placed on probation or otherwise disciplined? _____

If YES, explain and attach documentation _____

Has licensee ever been requested to appear before your Board? _____

If YES, explain _____

Derogatory information, if any _____

Comments, if any _____

BOARD SEAL

Signed: _____
Title: _____
State Board: _____ Date: _____

VERIFICATION OF PHARMACIST LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO THE BOARD IN WHICH THE BUSINESS IS LOCATED TO OPERATE AS AN OUT-OF-STATE MAIL SERVICE PHARMACY. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD:

I am applying for a registration to operate as an Out-of-State Mail Service Pharmacy in the State of Montana. The Board of Pharmacy requires this form to be completed by the state where the business is located or the Pharmacist-in-Charge is employed. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **MT BOARD OF PHARMACY, P.O. BOX 200513, HELENA, MT 59620-0513 (DELIVERY 301 SOUTH PARK AVENUE, 4TH FLOOR HELENA, MT 59601)** Your early response is appreciated.

(Signature) Name: _____
(Please print)

Address: _____

License Number is: _____

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF _____

State of: _____

Full Name of Licensee: _____

License No. _____ Issue Date: _____

License is current? _____ If NO, explain _____

Has license been suspended, revoked, placed on probation or otherwise disciplined? _____

If YES, explain and attach documentation _____

Has licensee ever been requested to appear before your Board? _____

If YES, explain _____

Derogatory information, if any _____

Comments, if any _____

BOARD SEAL

Signed: _____
Title: _____
State Board: _____ Date: _____

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PHARMACIST-IN-CHARGE FORM

LICENSE REQUIREMENTS 24.174.1003(1)(2)(3) ARM OUT OF STATE MAIL SERVICES PHARMACIES:

Complete the Mail Order Pharmacy application
Submit the Pharmacist-in-Charge form and the Non-Pharmacist-Owner agreement if owner of pharmacy is different than Pharmacist-in-Charge

ADDITIONAL RULES:

24.174.1003 Identification of Pharmacist-in-Charge of Dispensing to Montana

1) Each out-of-state mail service pharmacy that ships, mails, delivers prescription drugs and/or devices and oversees the pharmacy services provided to patients in Montana shall identify a pharmacist-in-charge of dispensing prescriptions for shipment to Montana and oversee the pharmacy services provided. Each pharmacist so identified shall meet the following requirements:

- (a) be licensed in good standing in the state in which the out-of-state mail service pharmacy is located;
- (b) be properly listed on the application form prescribed by the board;
- (c) comply with all applicable Montana laws and rules; and
- (d) notify the Montana board promptly in writing of any changes in the licensure status of the pharmacist-in-charge and any disciplinary actions initiated and/or finalized against the pharmacist's license.

(2) When the pharmacist-in-charge of an out-of-state mail service pharmacy ceases to be the pharmacist-in-charge, the pharmacist will be held responsible for notifying the board in writing of such termination of services.

(3) Within 72 hours of termination of services of the pharmacist-in-charge, a new pharmacist-in-charge must be designated in writing on the appropriate board-approved form and filed with the board.

APPLICATION PROCEDURES:

When the application file is complete, it will be processed and considered by Board staff for permanent registration. The applicant may be notified if additional information is required or if required to appear before the Board for an interview.

If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-routine applications may take up to 120 days to process.

Verification of licensure must be sent directly to the state board in which the business is located or the pharmacist-in-charge is employed. Please contact the state board prior to sending the request as some states may charge a fee for verification.

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STATEMENT OF PHARMACIST-IN-CHARGE

For the purposes of satisfying the requirements of ARM 24.174.1003(1) the following agreement has been entered into and submitted to the Montana Board of Pharmacy:

Name of Pharmacy/Business: _____ License Number: _____

Name of Pharmacist/Person-in-Charge (Please Print)

Address of Pharmacy _____

City _____ State _____ Zip Code _____

Owner of Pharmacy/Business _____
(Please complete "Non-Pharmacist-Owner agreement if owner of pharmacy is different than P.I.C.)

The signature below indicates that the individual is the Pharmacist/Person-in-Charge of the above named Pharmacy/Business and will be the Pharmacist/Person-in-Charge until the present license expires: that the undersigned agrees fully and promptly to comply with the applicable federal laws, laws of the State of Montana, and the rules and regulations of the Board of Pharmacy governing this application, applicants business, and the sale of permitted drugs, pharmaceuticals, and commodities.

Signature _____ Date _____

Please retain a copy of this form in the pharmacy and send the original to the Board office

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PHARMACIST-IN-CHARGE AGREEMENT
(NON-PHARMACIST OWNER)

For purposes of satisfying the intent of 24.174.1003(1) the following agreement has been entered into and submitted to Montana Board of Pharmacy, PO Box 200513, Helena, MT 59620-0513:

I, _____, duly designated agent for the _____ (pharmacy owner/corporation) do hereby vest exclusive authority in _____, a licensed pharmacist in the State of Montana, the State in which the out-of-state mail service pharmacy is licensed **or** person-in-charge Pharmacist/Person-in-Charge for the _____ (name of pharmacy/business) Pharmacy/Business License Number _____ to perform as follows:

That _____, pharmacist/person, license number _____, shall have exclusive authority to make and implement any decision which may directly or indirectly involve compliance with any of the provisions of Title 37, Chapter 7, Montana Code Annotated and Title 8, Chapter 40 of the Administrative Rules of Montana. That the parties hereto expressly agree and understand that in no event shall any person or persons, by virtue of his or their position in the corporation or for any other reason, substitute his or their judgment for that of the pharmacist/person-in-charge on matters involving the aforementioned compliance; that the parties further agree and understand that the continued right of the corporation to own and operate this pharmacy is contingent upon the existence and implementation of this agreement; and that the corporation agrees and understands that at such time as a new pharmacist/person-in-charge is designated, that a new agreement must be executed with that person and submitted to the Montana Board of Pharmacy.

Signed and dated this _____ day of _____, 20_____.

Agent for the Corporation

Pharmacist/Person-in-Charge

Please retain a copy of this form and send the original to the Board office