

## Hospital Pharmacy Closing Statement Must be filed within 30 days of a hospital pharmacy closing

Hospital Pharmacy Information							
	Owner of Pharmacy/Corporation Name:						
_							
Α	Hospital Pharmacy Name:						
_	Date of Closing:						
Di	Disposition of Controlled Substances (Narcotics, Controlled Drugs, Targeted Substances)						
	Name of Pharmacy <i>or</i> Wholesaler:	Accreditation Number:					
	Address:						
В	, radicess.						
	City/Town:	Province:	Postal Code:				
	Email:		Phone number:				
	Liliali.	Email:					
Di	sposition of Prescription Drugs (Prescription [	Orug List. Schedule	☐ Same as Section B				
Dis	sposition of Prescription Drugs (Prescription I Name of Pharmacy <i>or</i> Wholesaler:	Orug List, Schedule	Accreditation Number:				
Dis	Name of Pharmacy <i>or</i> Wholesaler:	Orug List, Schedule					
Dis		Orug List, Schedule					
Dis	Name of Pharmacy <i>or</i> Wholesaler:	Province:					
	Name of Pharmacy <i>or</i> Wholesaler:  Address:		Accreditation Number:				
	Name of Pharmacy <i>or</i> Wholesaler:  Address:		Accreditation Number:				
	Name of Pharmacy <i>or</i> Wholesaler:  Address:  City/Town:		Accreditation Number:  Postal Code:				
С	Name of Pharmacy <i>or</i> Wholesaler:  Address:  City/Town:  Email:	Province:	Postal Code:  Phone number:				
С	Name of Pharmacy <i>or</i> Wholesaler:  Address:  City/Town:  Email:  sposition of Non-Prescription Drugs (Schematical Schematical	Province:	Postal Code:  Phone number:  Same as Section C				
С	Name of Pharmacy <i>or</i> Wholesaler:  Address:  City/Town:  Email:	Province:	Postal Code:  Phone number:				
С	Name of Pharmacy <i>or</i> Wholesaler:  Address:  City/Town:  Email:  sposition of Non-Prescription Drugs (Schematical Schematical	Province:	Postal Code:  Phone number:  Same as Section C				
C	Name of Pharmacy or Wholesaler:  Address:  City/Town:  Email:  sposition of Non-Prescription Drugs (Schen Name of Pharmacy or Wholesaler:  Address:	Province:	Postal Code:  Phone number:  Same as Section C  Accreditation Number:				
С	Name of Pharmacy <i>or</i> Wholesaler:  Address:  City/Town:  Email:  sposition of Non-Prescription Drugs (Schename of Pharmacy <i>or</i> Wholesaler:	Province:	Postal Code:  Phone number:  Same as Section C				
C	Name of Pharmacy or Wholesaler:  Address:  City/Town:  Email:  sposition of Non-Prescription Drugs (Schen Name of Pharmacy or Wholesaler:  Address:	Province:	Postal Code:  Phone number:  Same as Section C  Accreditation Number:				



## Hospital Pharmacy Closing Statement Must be filed within 30 days of a hospital pharmacy closing

Di	sposition of Patie	☐ Same as Section D					
	Name of Hospital Pharmacy:			Accreditation Number:			
-	Address:						
- -	City/Town:		Province:	City/Town:			
	Email:			Phone number:			
E	Disposition of Patient Records Agreement  To be completed by the Hospital CEO/Designated Contact of the pharmacy accepting the patient records from the closing pharmacy.  I agree to accept the patient records from the pharmacy submitting this closing statement. I acknowledge that in doing so I am responsible for making these records available to patients, the College (for assessment purposes), and the Ministry of Health and Long Term Care (for audit purposes).						
	Signature of Hospital Cl	EO/Designated Contact accepting records:	OCP Number: (if applicable)	Date:			
-	Email:			Phone number:			
Removal of Signs & Symbols Relating to the Practice of Pharmacy							
F	Date removed:	: Additional Comments:					
Closing Statement Completed by							
	Signature of Hospital CEO  OCP Number: (if applicable)			Date:			
G	Email:			Phone number:			

Submit completed form by email to <a href="mailto:pharmacyapplications@ocpinfo.com">pharmacyapplications@ocpinfo.com</a>, or by fax to 416-847-8399,

or by mail to the attention of Pharmacy Applications & Renewals at 483 Huron St, Toronto, ON M5R 2R4

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