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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). |