COLLABORATIVE PHARMACY PRACTICE NOTIFICATION

Collaboration Information

Is the collaboration between one or more pharmacists and a physician group? ☐ Yes ☐ No

Name of the physician group (if applicable): _____

Pharmacist Information

Provide the name and contact information for the pharmacist who will engage in collaborative pharmacy practice pursuant to this Practice Notification. If there is more than one pharmacist, please utilize page 3.

Name: _____ **License Number:** _____
First Middle Last Suffix

Preferred Contact Information

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Email Address: _____ **Telephone Number:** _____

Signature: _____

Physician Information

Provide the name and contact information for the physician who will engage in collaborative pharmacy practice pursuant to this Practice Notification. If there is more than one physician, please utilize page 4.

Name: _____ **License/Permit Number:** _____
First Middle Last Suffix

License/Permit Type: ☐ **MD** ☐ **DO**

Preferred Contact Information

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Email Address: _____ **Telephone Number:** _____

Signature: _____

Practice Location

List all locations where the collaborative pharmacy practice will occur pursuant to this Practice Notification. If there is more than one practice location, please utilize page 5.

Primary Practice Location

Business Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Effective Date

Provide the date that the Collaborative Pharmacy Practice Agreement that is associated with this Practice Notification will become effective. The effective date must be a future date. It cannot be earlier than the date that this Practice Notification is submitted to the West Virginia Board of Pharmacy.

The Practice Agreement associated with this Practice Notification will become effective on: _____

Certification

The pharmacist and the physician must certify the information below. If there is more than one pharmacist and/or physician who will engage in collaborative pharmacy practice pursuant to this Practice Notification, only one pharmacist and one physician need to complete the certification. The providers completing the certification will be the provider contacts for communications concerning this Practice Notification and the associated Practice Agreement.

On behalf of all providers who are parties to this Practice Notification and the associated Collaborative Pharmacy Practice Agreement, we hereby certify that:

- Each pharmacist, who is listed herein, has been verified as eligible for collaborative pharmacy practice by the West Virginia Board of Pharmacy.
- Each physician, who is listed herein, is eligible to serve as a collaborating physician.
- A Collaborative Pharmacy Practice Agreement has been agreed upon and executed by the pharmacist(s) and physician(s) which is consistent with each physician's scope of practice, each pharmacist's education, training and experience, and includes, at a minimum, the protocols required by W. Va. Code R. § 11-8-4 *et seq*.
- Each collaborating pharmacist will maintain a copy of the Collaborative Pharmacy Practice Agreement at his or her place of practice and the collaborating parties will provide a copy to any of their licensing boards upon request.
- Collaborative pharmacy practice shall only occur after informed consent of the patient, which must be noted in the patient medical record.
- The parties acknowledge that the Collaborative Pharmacy Practice Agreement does not include the management of controlled substances.
- If participants to the Collaborative Pharmacy Practice Agreement changes, or if the Collaborative Pharmacy Practice Agreement is terminated for any reason, we will provide written notice to the West Virginia Board of Pharmacy.

Receipt of this Practice Notification will be provided to the pharmacist(s) and the physician(s) via the email addresses provided on this notification.

_____	_____	_____
Pharmacist's Printed Name	Pharmacist's Original Signature	Date
_____	_____	_____
Physician's Printed Name	Physician's Original Signature	Date

Filing Instructions

Complete notification form online and the $50.00 filing fee will be paid online to the West Virginia Board of Pharmacy.

West Virginia Board of Pharmacy
2310 Kanawha Blvd E.
Charleston, West Virginia 25311

Additional Pharmacist Information

If there are more than three additional pharmacists, multiple copies of this page can be submitted.

Name: ______________________________ **License Number:** ____________

First Middle Last Suffix

Preferred Contact Information

Street Address: ______________________________

City: ____________ **State:** ____________ **Zip Code:** ________ **County:** ____________

Email Address: ______________________ **Telephone Number:** ____________

Signature: ______________________________

Name: ______________________________ **License Number:** ____________

First Middle Last Suffix

Preferred Contact Information

Street Address: ______________________________

City: ____________ **State:** ____________ **Zip Code:** ________ **County:** ____________

Email Address: ______________________ **Telephone Number:** ____________

Signature: ______________________________

Name: ______________________________ **License Number:** ____________

First Middle Last Suffix

Preferred Contact Information

Street Address: ______________________________

City: ____________ **State:** ____________ **Zip Code:** ________ **County:** ____________

Email Address: ______________________ **Telephone Number:** ____________

Signature: ______________________________

Additional Physician Information

If there are more than three additional physicians, multiple copies of this page can be submitted.

Name: ____ **License/Permit Number:** __________

First Middle Last Suffix

License/Permit Type: ☐ **MD** ☐ **DO**

Preferred Contact Information

Street Address: ____

City: ____________________ **State:** ______________ **Zip Code:** ________ **County:** __________

Email Address: ________________________________ **Telephone Number:** __________________

Signature: ____

Name: ____ **License/Permit Number:** __________

First Middle Last Suffix

License/Permit Type: ☐ **MD** ☐ **DO**

Preferred Contact Information

Street Address: ____

City: ____________________ **State:** ______________ **Zip Code:** ________ **County:** __________

Email Address: ________________________________ **Telephone Number:** __________________

Signature: ____

Name: ____ **License/Permit Number:** __________

First Middle Last Suffix

License/Permit Type: ☐ **MD** ☐ **DO**

Preferred Contact Information

Street Address: ____

City: ____________________ **State:** ______________ **Zip Code:** ________ **County:** __________

Email Address: ________________________________ **Telephone Number:** __________________

Signature: ____

Additional Practice Locations

If there are more than five additional practice locations, multiple copies of this page can be submitted

Business Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Business Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Business Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Business Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____

Business Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **County:** _____