NORTH CAROLINA BOARD OF PHARMACY
CLINICAL PHARMACIST PRACTITIONER
CHANGE OF STATUS FORM

Print Form

FORMS MUST BE ORIGINAL -- FAXED FORMS WILL NOT BE ACCEPTED.

This form can be used for a change in practice site or a change in supervising physician within a previously approved physician group / protocol.

Submit all material to: NC Board of Pharmacy
Attention: Deborah Stump
6015 Farrington Road, Suite 201
Chapel Hill, NC 27517

Please complete the form in every detail and mail the **original** to the NC Board of Pharmacy. The form should be typewritten or neatly printed.

Required materials to keep on file at CPP practice sites:

- CME documentation (see rule 21 NCAC 46.3101)
- Signed CPP protocol with primary supervising physician

Suggested materials to keep on file at CPP practice sites:

- N.C. General Statutes governing clinical pharmacist practitioners (90-18.4)
- Regulations of the NC Board of Pharmacy and the NC Medical Board
- Change of Status Form acknowledgment document from the NC Board of Pharmacy
- Photocopy of annual registration application and certificate
- Photocopy of completed Change of Status form(s) submitted to the Board
- Photocopy of correspondence sent to and received from the Boards
- Blank Change of Status form and instructions for future use

There is no fee required for the Change of Status form. Please notify the Board's office in writing when employment has been terminated. Please include the name of the practice, practice address, name of the primary and backup supervising physician(s) and effective date.

*****Please note that this form may be administratively approved.***

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FORMS MUST BE TYPEWRITTEN OR NEATLY PRINTED.

I. PLEASE CHECK ALL THAT APPLY:

☐ Add/change site with same physician group and same protocols. Complete pages 1, 2, and 4.

☐ Add/change supervising physician with same physician group and same protocols. Complete pages 1, 3, and 4.

II. CLINICAL PHARMACIST PRACTITIONER INFORMATION:

CPP Full Name *(first):* _____ *(middle):* _____ *(last):* _____

Name of Principal Practice: _____

Practice Address: _____

Practice Phone #: _____ Home Phone #: _____

Practice Fax #: _____ Home Fax #: _____

Home Address: _____

Date of Birth *(mm):* ____ *(dd):* ____ *(yyyy):* _____ NC CPP Approval #: _____

Preferred mailing address: ☐ home ☐ work

Preferred public address (will be listed on the Internet): ☐ home ☐ work

County in which practice is located: _____ County in which you live: _____

III. CURRENT PRIMARY SUPERVISING PHYSICIAN INFORMATION:

Primary Supervising Physician Name: _____

Name of Physician's Principal Practice: _____

Practice Address: _____

Practice Phone #: _____ NC Medical License #: _____

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ADD/CHANGE PRACTICE SITE(S) WITH SAME PHYSICIAN GROUP AND SAME PROTOCOL

Complete the section below. Please attach additional sheets if necessary.

◯ *Add Practice Site* ◯ *Remove Practice Site*

Practice Name: _____

Practice Address: _____

Practice Phone #: _____ Practice Fax #: _____

◯ *Add Practice Site* ◯ *Remove Practice Site*

Practice Name: _____

Practice Address: _____

Practice Phone #: _____ Practice Fax #: _____

◯ *Add Practice Site* ◯ *Remove Practice Site*

Practice Name: _____

Practice Address: _____

Practice Phone #: _____ Practice Fax #: _____

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ADD/CHANGE SUPERVISING PHYSICIAN(S) WITH SAME PHYSICIAN GROUP AND SAME PROTOCOL

Complete the section below. Please attach additional sheets if necessary.

◯ *Add Primary Physician* ◯ *Remove Primary Physician (if you are removing a primary physician, you must be adding a primary physician.)*

◯ *Add Backup Physician* ◯ *Remove Backup Physician*

Physician Name: ____________________

Name of Physician's Principal Practice: ____________________

Practice Address: ____________________

Practice Phone #: ____________________ NC Medical License #: ____________________

◯ *Add Primary Physician* ◯ *Remove Primary Physician (if you are removing a primary physician, you must be adding a primary physician.)*

◯ *Add Backup Physician* ◯ *Remove Backup Physician*

Physician Name: ____________________

Name of Physician's Principal Practice: ____________________

Practice Address: ____________________

Practice Phone #: ____________________ NC Medical License #: ____________________

◯ *Add Primary Physician* ◯ *Remove Primary Physician (if you are removing a primary physician, you must be adding a primary physician.)*

◯ *Add Backup Physician* ◯ *Remove Backup Physician*

Physician Name: ____________________

Name of Physician's Principal Practice: ____________________

Practice Address: ____________________

Practice Phone #: ____________________ NC Medical License #: ____________________

◯ *Add Primary Physician* ◯ *Remove Primary Physician (if you are removing a primary physician, you must be adding a primary physician.)*

◯ *Add Backup Physician* ◯ *Remove Backup Physician*

Physician Name: ____________________

Name of Physician's Principal Practice: ____________________

Practice Address: ____________________

Practice Phone #: ____________________ NC Medical License #: ____________________

Print Form

CERTIFICATION OF UNDERSTANDING AND COMPLIANCE:

The undersigned have read this form and certify that the information contained herein is correct to the best of their knowledge.

The undersigned further certify that they have carefully read and understand the law and regulations regarding clinical pharmacist practitioners. The undersigned agree to fully comply with such statutes and regulations.

The undersigned physician accepts responsibility for the applicant's conduct as a clinical pharmacist practitioner under the physician's supervision and understands that conduct which violates the laws and regulations governing clinical pharmacist practitioners may subject the supervising physician to sanctions including suspension or revocation of the physician's license to practice medicine in North Carolina.

_____ _____

Date Clinical Pharmacist Practitioner (original signature)

Full Name (typed or printed legibly): _____

_____ _____

Date *Primary Supervising Physician (original signature)

Full Name (typed or printed legibly): _____

**If the primary supervising physician is changing through submission of this form, the new primary supervising physician should sign.*