



REQUEST FOR INCREASE IN TECHNICIAN TO PHARMACIST RATIO

Please complete online and submit by email.

1. Institution or Company: NC Permit #:

2. Address: City: State: Zip:

3. Describe Pharmacy Practice Activity (*Hospital Inpatient, Outpatient, Community Pharmacy, Nursing Home Pharmacy, etc.*):

4. Describe systems used, including the use of technology:

5. Prescriptions or Order Volume(s) [use averages from most recent week or month or other convenient period noting weekday and weekend figures]:

6. Staffing Levels **[Use "P" for Pharmacist and "T" for Technician]** *See example at bottom of page 2 of this form.*

A. **Current** Staffing Levels:

	AM				PM			
	3:00	6:00	9:00	12:00 Noon	3:00	6:00	9:00	12:00 Midnight
Sunday								
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								

(CURRENT)

B. **Proposed** Staffing Levels:

	AM				PM			
	3:00	6:00	9:00	12:00 Noon	3:00	6:00	9:00	12:00 Midnight
Sunday								
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								

(PROPOSED)

NOTE: If you are requesting, in whole or in part, an increase in the pharmacist:technician ratio above 1:3, please attach a separate, specific description of how each technician will be employed in the dispensing process.

7. List ALL Technicians, Length of Service, and 15-digit PTCB# as applicable. Add pages as necessary:

8. Describe how supervision of total technician staff will occur:

9. Describe duties of additional technicians:

10. I, _____, accept complete responsibilities for supervision of all Pharmacy Technicians including personnel approved by the Board from this request.
[Pharmacist-Manager's Name]

I declare that I am the pharmacist-manager referred to in #10 above and that the statements herein are true and complete.

Date (click drop-down arrow for calendar):

NOTE: Approval of this request is binding on the applicant pharmacist-manager and any subsequent pharmacist-manager. Should a subsequent pharmacist-manager wish to no longer be responsible for an approved pharmacist:technician ratio, he/she must notify the Board in writing that this approval should be voided.

Instructions: Click "SUBMIT BY EMAIL" at the top of page 1 of this form or mail to:
 NC Board of Pharmacy
 Attention: Debbie Stump
 6015 Farrington Road, Suite 201
 Chapel Hill, NC 27517

(Or you may fax the form to (919) 246-1056, attention Debbie Stump.)

OFFICE USE ONLY

APPROVED / DENIED

Date: _____

Signature: _____

Once the request is approved by the NC Board of Pharmacy, a copy of this application must be kept on file in the pharmacy at all times.

Example - In a pharmacy with 1 pharmacist and 2 technicians on duty from 9am - 9pm Monday through Friday and 1 pharmacist and 1 technician on Saturday and Sunday, staffing levels would be:

	AM				PM			
	3:00	6:00	9:00	12:00 Noon	3:00	6:00	9:00	12:00 Midnight
Sunday	-	-	1P/1T	1P/1T	1P/1T	1P/1T	1P/1T	-
Monday	-	-	1P/2T	1P/2T	1P/2T	1P/2T	1P/2T	-
Tuesday	-	-	1P/2T	1P/2T	1P/2T	1P/2T	1P/2T	-
Wednesday	-	-	1P/2T	1P/2T	1P/2T	1P/2T	1P/2T	-
Thursday	-	-	1P/2T	1P/2T	1P/2T	1P/2T	1P/2T	-
Friday	-	-	1P/2T	1P/2T	1P/2T	1P/2T	1P/2T	-
Saturday	-	-	1P/1T	1P/1T	1P/1T	1P/1T	1P/1T	-