New Brunswick College of Pharmacists
Ordre des pharmaciens du Nouveau-Brunswick

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www.nbpharmacists.ca info@nbpharmacists.ca

Temporary Pharmacy Closure Form

Pharmacy information

Pharmacy name:
____

Pharmacy certificate of operation number:
____

Pharmacy Manager (first and last name):
____

Pharmacy Manager registration number:
____

Closure Details

Reason for Temporary Closure:
____
____
____

Closure Start Date (YYYY-MM-DD): ______________________________ (mandatory)

Closure End Date (YYYY-MM-DD): ______________________________

If this closure is unplanned, please describe your plans for maintaining premises security and accessing pharmacy records**:**
____
____
____

Patient Communication

Method(s) of Informing Patients of Closure: (select all that apply)

☐ In-Store Signage ☐ Email/Text Notification
☐ Phone Messages ☐ Website Notification
☐ Other (please specify): ____

Continuity of Care

Arrangements for Continuity of Care:
____
____
____

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Alternative Pharmacy for Prescription Transfers:

Pharmacy Name: ______________________________________
Pharmacy certificate of operation number P000): ____

Emergency Contact Information

Emergency Contact Name: ____
Emergency Contact Phone Number: ____
Emergency Contact Email: ____

Declaration

- ❑ I hereby declare that the information provided in this form is accurate and complete to the best of my knowledge.
- ❑ I acknowledge my professional obligations as outlined in the Temporary Pharmacy Closure Policy.
- ❑ I agree to notify the College when the pharmacy has reopened

Signature: ________________________________ Date (YYYY-MM-DD): ______________________

Once completed, please send this form via email to registrations@nbpharmacists.ca. The form should be submitted to the College seven (7) days prior to the start of the temporary closure, when possible.