



State of Alaska  
 Department of Commerce, Community, and Economic Development  
 Division of Corporations, Business and Professional Licensing  
 BOARD OF PHARMACY  
**Physical Address:** 333 Willoughby Avenue, 9<sup>th</sup> Floor, Juneau, Alaska 99801  
**Mailing Address:** P.O. Box 110806, Juneau, Alaska 99811-0806  
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**CHANGE OF PHARMACY MANAGER**

**FEE: \$5.00 (Payable to the State of Alaska)**

**Alaska Statute 08.80.330. LICENSED PHARMACIST APPOINTED AS "PHARMACIST-IN-CHARGE."** (a) Each pharmacy shall have a pharmacist-in-charge. Whenever an applicable law or regulation requires or prohibits action by a pharmacy, responsibility shall be that of the owner and the pharmacist-in-charge, whether the owner is a sole proprietor, partnership, association, corporation, or otherwise. The pharmacist-in-charge shall ensure compliance with all laws and regulations governing the operation of the pharmacy. A licensed pharmacist appointed as pharmacist-in-charge of a pharmacy shall immediately advise the board of that appointment.

(b) A license may not be issued to a pharmacy unless there is a licensed registered pharmacist-in-charge whose name appears on the face of the license.

**PHARMACIST-IN-CHARGE:** Within 10 days of appointment as the new pharmacist-in-charge, you must notify the division in writing by completing this form. A personal check, certified check, or money order in the amount of \$5, payable to the "State of Alaska" **must** accompany this form.

**CHANGE OF MANAGER FOR A WHOLESALE DISTRIBUTOR:** Within 30 days of a change in facility manager, the new facility manager must submit a resume and completed fingerprint cards for evaluation and investigation by the Department of Public Safety. Contact the Division for blank fingerprint cards and instructions. A personal check, certified check, or money order in the amount of \$5, payable to the "State of Alaska" **must** accompany this form.

**Name of Pharmacy or Wholesale Drug Distributor:** \_\_\_\_\_

**Alaska License Number:** \_\_\_\_\_

**License Type:**     Retail/Institutional       Drug Room  
                           Out-of-State                       Wholesale Drug Distributor

**New Pharmacy (Facility) Manager:** \_\_\_\_\_

**Date of Appointment:** \_\_\_\_\_

**License Number:** \_\_\_\_\_      **State of Issue:** \_\_\_\_\_

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date