

Return To: Computer Science Corporation
PO Box 4610
Rensselaer NY 12144-4610

SUPERVISING PHARMACIST AGREEMENT

Supervising Pharmacist:

| Last Name (Print) | First | M.I. |
|---|-------|--|
| _____ Supervising Pharmacist License/Registration # | _____ | _____ |
| | | _____ Supervising Pharmacist NPI |
| | | _____ Supervising Pharmacist MMIS Provider # |

Pharmacy Information:

Pharmacy Name: _____

Address: _____

| | |
|--|-----------------------------------|
| _____ Pharmacy License/Registration # | _____ Pharmacy NPI |
| | _____ Pharmacy MMIS Provider # |

I agree to assume the responsibilities, as defined by State and Federal Laws, as the Supervising Pharmacist of _____,
Pharmacy Name
effective as of _____.

I agree to notify the State Pharmacy Board and the NYS Department of Health, Bureau of Enrollment, of any change of my Supervising Pharmacist status.

Signature of Supervising Pharmacist **Date Signed**

Pharmacy Owner:

I understand enrollment of a Supervising Pharmacist is a precondition for NYS Medicaid reimbursement.

Owner's Name (PRINT)

Owner's Signature (SIGNATURE STAMPS ARE NOT PERMITTED) **Date Signed**

Passport size photo affixed to a separate 8 ½" x 11" sheet of paper **with supervising pharmacist's name, social security number and name of pharmacy.**