

Return To: eMedNY
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.**