Pharmacy Examining Board

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INSTITUTIONAL TECH-CHECK-TECH PILOT PROGRAM REPORT

COMPLETED REPORTS MUST BE SUBMITTED TO THE BOARD ON OR BEFORE JULY 31.
PLEASE NOTE: ADDITIONAL DETAILS MAY BE REQUESTED BY THE BOARD ON A CASE BY CASE BASIS.

DBA NAME OF PHARMACY: (This must be the name on the pharmacy license.)	**PHARMACY TELEPHONE:**	**PHARMACY WI LICENSE NUMBER:**
PHARMACY ADDRESS (pharmacy location waiver applies)**:** number, street, city, zip code		
MANAGING PHARMACIST:	**EMAIL:**	
TECH-CHECK-TECH SUPERVISING PHARMACIST:	**EMAIL:**	

OVERALL ACCURACY RATES FOR PHARMACY

FOR TIME PERIOD ☐ **_____/_____/_____ TO _____/_____/_____**
Month Day Year Month Day Year

Total number of TCT final checks	
Total number of TCT final checks audited by a pharmacist	
Total number of errors identified in the TCT final check pharmacist audit that were wrong drug, wrong dose, or wrong dosage form	
Number of pharmacist hours reallocated to other patient care activities	
Description of patient care activities from reallocated pharmacist hours	

I/We declare that the foregoing statements and attached corresponding documents are true and correct to the best of my/our knowledge and belief.

_____ _____ _____
TCT Supervisor Signature WI License Number Date

_____
Printed Name of person signing above