Pharmacy Examining Board

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COMMUNITY PHARMACY TECH-CHECK-TECH (cTCT) PILOT PROGRAM APPLICATION

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

Wisconsin Department of Safety and Professional Services

We attest that we have read, understand, and will comply with all requirements of the community Tech-Check-Tech pilot program; the community Tech-Check-Tech pilot program will be utilized to provide direct patient care services and is not intended to reduce staffing levels; pharmacist to technician ratio will be maintained according to the Rules of the Pharmacy Examining Board; the application covers only the pharmacy indicated above and at the location specified; and that we will comply with the provisions of the Wisconsin Statutes and the Rules of the Pharmacy Examining Board.

_____ _____ _____
Supervising Pharmacist Signature | WI License Number | Date

_____
Printed name of person signing above

_____ _____ _____
Managing Pharmacist Signature | WI License Number | Date

_____
Printed name of person signing above