Committed to Equal Opportunity in Employment and Licensing

Pharmacy Examining Board

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

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 cTCT final checks	
Total number of cTCT final checks audited by a pharmacist	
Total number of errors identified in the cTCT final check pharmacist audit that were wrong drug, wrong dose, or wrong dosage form	
Total 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.

_____ _____ _____
Supervising Pharmacist Signature WI License Number Date

_____
Printed Name of person signing above