*State of West Virginia*

**West Virginia Board of Medicine**
**101 Dee Drive, Suite 103**
**Charleston, WV 25311**
**Telephone 304.558.2921**
**Fax 304.558.2084**
**Website: www.wvbom.wv.gov**


# INSTRUCTIONS FOR COLLABORATIVE PHARMACY PRACTICE

West Virginia Legislative Rule 11 CSR 8 (copy enclosed) provides for a medical doctor and pharmacist to engage in collaborative pharmacy practice in the State of West Virginia, in accordance with provisions of this rule.

Attached is an application form which must be completed in full and returned to the Board of Medicine for approval prior to the medical doctor and pharmacist engaging in collaborative pharmacy practice. Documentation of Board of Pharmacy approval for the pharmacist must be attached. A processing fee of $100 must also be included with the application (make your check or money order payable to the West Virginia Board of Medicine). A medical doctor seeking to hold a collaborative pharmacy practice must hold an unrestricted, active West Virginia medical license.

A typewritten collaborative pharmacy practice protocol must be attached to the Board's application form and must comply with the provisions of 11 CSR 8 4.3. Both the medical doctor and pharmacist must sign and date the typewritten protocol.

Once written approval is received from the Board, the collaborative pharmacy practice protocol is in effect for a two (2) year period from the date of issuance. Modifications may be made in between the two (2) year period of existence of each protocol, subject to the $100 processing fee.

For questions regarding this application process, call the Board Offices at 304.558.2921 x70011, Sheree Thompson, or reach her by e-mail at Sheree.J.Thompson@WV.gov.

# West Virginia Board of Medicine

## Application for Collaborative Pharmacy Practice

(Please type or print)

**Name of Medical Doctor:** ______________________________

**West Virginia Medical License No:** ______________________________

**Office Address:** ______________________________
(physical location)

______________________________
(city) (state) (zip code)

**Telephone Number:** (_____)______________________ **Fax Number:** (_____)______________________

**Name of Collaborative Pharmacy Practice Pharmacist:** ______________________________
(Attach Board of Pharmacy Approval)

**West Virginia License No:** ______________________________

**Pharmacy Practice Location Address:**

______________________________
(name of pharmacy)

______________________________
(physical location)

______________________________
(city) (state) (zip code)

**Pharmacy Practice Location Address:**

______________________________
(name of pharmacy)

______________________________
(physical location)

______________________________
(city) (state) (zip code)

**Pharmacy Practice Location Address:**

______________________________
(name of pharmacy)

______________________________
(physical location)

______________________________
(city) (state) (zip code)

**Pharmacy Practice Location Address:**

______________________________
(name of pharmacy)

______________________________
(physical location)

______________________________
(city) (state) (zip code)

**FEE: $100 (check or money order payable to):**
West Virginia Board of Medicine

| Reg. No. |
| --- |
| BOARD USE ONLY |

## CERTIFICATION

I have reviewed the current copy of Legislative Rule 11 CSR 8 (copy enclosed) governing the Collaborative Pharmacy Practice. I have read and understand Legislative Rule 11 CSR 8 and agree to abide by the Rule.

____________________________________ _____________________________

Original Signature of Medical Doctor | Today's Date