South Dakota Board of Pharmacy

4001 W. Valhalla Blvd., Ste. 106
Sioux Falls, SD 57106
Phone: 605-362-2737
Fax: 605-362-2738

Administrative Rule Wavier or Modification Request

Directions: (for completing the form) The following form must be completed and submitted to the office for review. Along with the form provide any policies and procedures documents that would be used to implement the request in your operation and organization. All requests for pharmacy waiver must be submitted by the pharmacist-in-charge. The pharmacist-in-charge must be available during the board meeting when request is to be discussed. All waivers must be submitted 2 weeks before the board meeting at which it will be brought for consideration.

To be completed by submitter

Is this a _____ new waiver request or a _____ renewal of a previous waiver?

Name & license number of the pharmacy _____

Name & license number of the pharmacist-in-charge _____

Name & license number for person who will oversee the waiver

_____

Location/Address where waiver will be implemented

_____

Rule number requested to be waived *(i.e. ARSD 20:51:xx)*_____

Timeframe for which the waiver is requested. *Requests must be reviewed at least annually and therefore must be for 1 year or less.*

_____

In a separate document the following must be provided with the submission of this form.

- Explain reason for waiver.
- Describe process/practice to be implemented with the waiver.
- Describe how the activities under the waiver will be monitored.

Submitter Name: _____ Date: _____

To be completed by South Dakota Board of Pharmacy office:

Waiver Request Status: ( ) Granted ( ) Denied Date of approval: Date of Expiration: