Return To: eMedNY PO Box 4610 Rensselaer NY 12144-4610

## SUPERVISING PHARMACIST AGREEMENT

Supervising Pharmacist:

Last Name (Print)	First	M.I.
Supervising Pharmacist License/Registration #		Supervising Pharmacist NPI
		Supervising Pharmacist MMIS Provider #
Pharmacy Information:		
Pharmacy Name:		
Address:		
Pharmacy License/Registratio	on #	Pharmacy NPI
		Pharmacy MMIS Provider #
I agree to assume the responsib Pharmacist of	ilities, as defined by Sta	te and Federal Laws, as the Supervising
Pharmacy Name effective as of		
	nacy Board and the NYS	Department of Health, Bureau of t status.
Signature of Supervising Phar	rmacist	Date Signed
Pharmacy Owner:		
I understand enrollment of a Sup reimbursement.	pervising Pharmacist is a	a precondition for NYS Medicaid
Owner's Name (PRINT)		
Owner's Signature (SIGNATU	RE STAMPS ARE NOT	PERMITTED) Date Signed
Passport size photo affixed to a	separate 8 1/2" x 11" she	et of paper with supervising

pharmacist's name, social security number and name of pharmacy.