

PHARMACY CLOSING FORM

**TO: IDFPR - Division of Professional Regulation
Drug Compliance Unit
9511 Harrison Street, Suite LL50
Des Plaines, IL 60016-1563**

FPR.DrugComplianceUnit@illinois.gov

Attention Investigator: _____

Please be advised that on: _____
(DATE)

**(Drug Compliance Unit must be notified no later than 30 days after closing
pursuant to Section 1330.790 of the Illinois Administrative Code)**

Pharmacy Name: _____

Pharmacy License #: 054. _____ / Controlled Substance #: 320. _____

DEA Registration #: _____

Located at (Address, City, State, Zip Code): _____

_____ will cease all business activity.

Complete the chart below regarding transfer of records and inventory:

Activity	Name	Address	Pharmacy License #
Controlled drugs will be transferred to:			054.
Non-controlled drugs will be transferred to:			054.
Prescription files will be transferred to:			054.
Records will be stored for 5 years at:			054.

The following items are enclosed:

- _____ Illinois Pharmacy License
- _____ Illinois Controlled Substance License

***Note:** DEA certificates and unused 222 forms MUST be returned directly to the DEA.

The final Controlled Substance Inventory:

- _____ **is enclosed**
- _____ **will be e-mailed to Investigator** after closing

SIGNATURE DATE

PRINT NAME

Please provide your cell or home phone number: _____