

AMERICAN PHARMACY SERVICES CORPORATION (APSC)

**PHARMACY RELIEF SERVICE (PRS)
PHARMACY APPLICATION**

Please Type or Print:

Pharmacy Name _____

Address _____

City _____ State _____ Zip _____

Owner/Manager/Director _____

Pharmacy Phone _____ Home Phone _____ E-Mail _____

Pharmacy Permit Number _____

Pharmacy Hours _____

Please check skills required of a Relief Pharmacist;

Computer _____ System _____

IV Mixture _____ Hyperalimentation _____ Chemotherapy Prep LTC Consulting _____

Nursing Home Disp. _____ Third-Party _____ Resuscitation Code Call _____

TERMS OF AGREEMENT

1. Relief Pharmacist referred by APSC can only be retained and scheduled through the PRS.
2. Participating APSC shareholder pharmacies will be charged \$55.00 per hour, APSC associate pharmacies will be charged \$60 per hour and **non-affiliated pharmacies will be charged \$65 per hour**. This amount includes the professional service and travel time of the Relief Pharmacist, and a program administrative fee. Pharmacies located in far eastern and western Kentucky will be charged an additional \$10 per hour.
3. A knowledgeable technician must be at the pharmacy while a Relief Pharmacist is scheduled.
4. Relief Pharmacists will be paid by APSC. Participating pharmacies will be invoiced at the beginning of the month for service rendered during the preceding month.

5. Cancellation of a Relief Pharmacist less than seventy-two (72) hours prior to the scheduled time of agreement will result in the pharmacy being invoiced for "first-day" charges.

TERMINATION OF AGREEMENT

1. For any violation of the aforementioned terms. Violation is subject to resource deemed appropriate by the APSC Board of Directors.
2. For willfully providing inaccurate information.
3. For activities not in keeping with accepted pharmacy practice as determined by the APSC Board of Directors.

ACCEPTANCE OF TERMS

I have read and agree to the stated terms. I certify that all information provided to the APSC PRS is accurate. I authorize the PRS, or their agent, to verify any or all information provided as part of this agreement.

I understand that the PRS will make every effort to secure a Relief Pharmacist for the date(s) requested, but accept the fact the PRS cannot guarantee results and that success is directly related to the amount of time between the request and need.

Please find enclosed our \$25.00 enrollment fee.

Name (Please Print) _____

Signed _____
Pharmacy Director

Accepted By: _____ Date _____
APSC Executive Vice President

Return to: American Pharmacy Services Corporation
Attention – Teresa Doris
102 Enterprise Drive
Frankfort, KY 40601