



State of Tennessee
Department of Health
Health Related Boards
Board of Pharmacy
665 Mainstream Drive
Nashville, TN 37243

Phone: 615-253-1299 Fax: 615-741-2722 Email: pharmacy.health@tn.gov

<https://www.tn.gov/health/health-program-areas/health-professional-boards/pharmacy-board/pharmacy-board/about.html>

BEDSIDE DELIVERY COMPLIANCE ATTESTATION

Date: _____ Pharmacy License Number: _____

Name of pharmacy (as it appears on license): _____

Name of hospital where bedside delivery of medications is provided directly to patients:

The Tennessee Board of Pharmacy has voted to allow bedside delivery of medications to patients of a hospital when the following conditions are met and approval has been received from Board staff:

1. 100% of patients are counseled (two-way video technology is acceptable, but a backup plan must be in place for technology failure to maintain compliance with this requirement);
2. Patient choice of pharmacy provider must be maintained;
3. Delivery must occur by registered pharmacy technician, pharmacist, or pharmacy intern;
4. Chain of custody must be direct from pharmacy to patient (may not be left with hospital staff);
5. Controlled substance prescriptions must be transmitted to the pharmacy by the hospital; the pharmacy technician must transport the hard copy prescription to the pharmacy unless a properly formatted, DEA compliant, e-prescription is transmitted; pharmacy may not dispense until hard copy is compared to the transmitted copy; and
6. A process must be in place to handle patient complaints.

I, the undersigned, do hereby swear and affirm compliance with all of the requirements listed above. I understand that by knowingly or purposefully making a false attestation that I may be subject to discipline under T.C.A. 63-10-305(6). Furthermore, I understand that this attestation establishes an on-going obligation of compliance. As such, should the ability to meet these requirements change, I will cease bedside delivery of medications and update the board immediately.

Pharmacist In Charge Name: _____ Date: _____

Pharmacist In Charge Signature: _____