**PHARMACY SOP**

**[COMPANY NAME]**

[Street Address]

[City, State and Zip]

[Email Address]

**Version 0.0.0**

**[Date]**

**department responsible**

| VERSION HISTORY | | | | |
| --- | --- | --- | --- | --- |
| VERSION | APPROVED BY | REVISION DATE | DESCRIPTION OF CHANGE | AUTHOR |
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**REVIEW PROCEDURE**

List how often the SOP should be reviewed and updated and who is responsible.

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**PURPOSE**

Specify what the SOP works to achieve.

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**SCOPE**

What work areas are covered in the SOP?

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**PROCEDURE**

In a step-by-step format, describe how tasks are carried out.

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**RESPONSIBILITY**

Specify clear responsibilities. Assess the competence and qualification level of each staff member responsible to ensure tasks can be carried out successfully.

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| **PROCESS NAME** | **TASK** | **PERSON RESPONSIBLE** |
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**KNOWN RISKS**

Describe any procedures of higher risk than usual. This will alert the staff to pay sufficient attention.

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**STAFF SIGNATURES**

Obtain signatures from each staff member to confirm that they have read, understood, and accepted their assigned responsibilities.

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| **STAFF MEMBER NAME** | **SIGNATURE** | **DATE** | **MANAGER NAME** | **SIGNATURE** | **DATE** |
|  |  |  |  |  |  |