

Kentucky Permit Number

PO \_\_\_\_\_

KENTUCKY BOARD OF PHARMACY  
State Office Building Annex, Suite 300  
125 Holmes Street  
Frankfort KY 40601  
Phone (502) 564-7910  
Fax (502) 696-3806



**APPLICATION FOR RESIDENT PHARMACY RENEWAL**

INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED.

Enclose a check or money order for \$100.00, made payable to 'Kentucky State Treasurer'.  
Please print legibly and complete this application; including the required original signature  
and return no later than June 30th.

Pharmacy Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Date of last controlled substance inventory \_\_\_\_\_

DEA Registration Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

**Ownership:**

Sole Proprietor

Partnership

Corporation

LLC

Other

Name and title for each owner/officer, including office and professional designation: (Use a separate piece of paper if necessary)

**Schedule of Hours:**

\*P.I.C. must notify the Board within fourteen (14) days of any changes in scheduled hours.

Monday \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M.  24 Hours

Tuesday \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M.  24 Hours

Wednesday \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M.  24 Hours

Thursday \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M.  24 Hours

Friday \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M.  24 Hours

Saturday \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M.  24 Hours

Sunday \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M.  24 Hours

Please indicate if closed for lunch. \_\_\_\_\_

**Type of Pharmacy** (Indicate by circling all that apply):

Retail Independent

Retail Chain

Hospital

Charitable

Infusion

Hospital-Ambulatory

Nursing Home

Nuclear

\*Internet

Mail Order

\* This must be circled if the pharmacy dispenses any prescriptions to citizens of the Commonwealth of Kentucky, in whole or in part, via the Internet [agent, internet broker or shipper]. If Internet is circled, VIPPS accreditation will be verified with the NABP.

# =====EMPLOYEE INFORMATION=====

Pharmacist-In-Charge(PIC): Name \_\_\_\_\_ KY License Number \_\_\_\_\_

**Note: 201 KAR 2:205 requires the pharmacist-in-charge to notify the Board within fourteen [14] calendar days of all pharmacist changes.**

**Employees:** Please provide a complete list of all employees licensed/registered with the Board. Use a separate sheet of paper if necessary.

NAME

License/Registration Number  
(Pharmacist, Pharmacist Intern or Pharmacy Technician)


Name, title and address of each non-pharmacist with keys to the pharmacy:


**\*Please submit the name, address and affiliation of all individuals, other than those previously identified in this application, responsible for pharmacy operations, management or staffing (eg. Pharmacy Services Management companies or consultants) on a separate sheet of paper.**

- 1. Does pharmacy ship medications outside of Kentucky?       YES       NO
- 2. Do you perform sterile compounding?       YES       NO
- 3. Do you perform nonsterile compounding?       YES       NO
- 4. Are you permitted in other states?       YES, please list below       NO

\_\_\_\_\_

- 5. Have you had a Pharmacy license/permit surrendered to or fined, suspended, probated, or revoked by any Board of Pharmacy which you have not previously reported to this Board?  
 Yes, attach an explanation       NO

The Board may refuse to issue or renew a permit, or suspend, temporarily suspend, revoke, fine or reasonably restrict any permit holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a permit. KRS 315.121.

*I hereby certify that the foregoing is true and correct and that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws.*

\_\_\_\_\_  
Signature of Owner

\_\_\_\_\_  
Date