KENTUCKY BOARD OF PHARMACY
State Office Building Annex, Suite 300
125 Holmes Street
Frankfort KY 40601
Phone (502) 564-7910
Fax (502) 696-3806
e-mail: pharmacy.board@ky.gov
http://pharmacy.ky.gov

Application for Special Limited Pharmacy Permit - Charitable Pharmacy

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer'. Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

1. Name of Facility _____

Physical Address of Facility _____
(Street and Number)

City _____ County _____ State _____Zip _____

Phone Number _____ Fax Number _____

Email Address _____

Mailing Address of Facility _____
(Street and Number)

City _____State _____Zip _____

Check and complete one of the following and attach proper fee:

☐ New Facility $125.00

Proposed date of Opening _____

(Filed with Board 30 days in advance of Opening) **or** Current Permit No. _____ Expiration Date _____
(In State where presently located)

☐ Change of Ownership . . . . . No Fee

Date of Proposed Acquisition _____

Name of Previous Owner(s) _____

(Confirmation statement of previous owner must be attached)

☐ Change of Address/Location . . . . . No Fee

Date of Proposed Relocation _____

Previous Address _____

☐ Name Change . . . . . No Fee

Previous Name _____

2. Ownership:

☐ Sole Proprietor ☐ Partnership ☐ Unincorporated Business ☐ Incorporated Business

Name and title for each owner/officer, including professional designation *(e.g. Pres. John Jones, PharmD)*

_____

_____

3. Pharmacist in Charge:

Name _____ KY License No. _____

Kentucky Pharmacy Regulation 201 KAR 2:205 requires Pharmacist in Charge to notify the Board within fourteen (14) calendar days of all pharmacist personnel changes.

4. Name and license/registration number of pharmacy employees.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

5. Name and title of each non-pharmacist with keys to the pharmacy:

_____

_____

6. Schedule of Hours:

Monday . . . . _____ A.M. to _____ P.M. Friday . . . _____ A.M. to _____ P.M.

Tuesday . . . _____ A.M. to _____ P.M. Saturday . . _____ A.M. to _____ P.M.

Wednesday _____ A.M. to _____ P.M. Sunday . . . _____ A.M. to _____ P.M.

Thursday . . . _____ A.M. to _____ P.M. **Please indicate if closed for lunch. _____**

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

7. Qualifying Questions

Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever been convicted of any felony under federal, state, and/or local laws?

☐ Yes, attach explanation ☐ No

Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever has a wholesale distributor license/permit revoked or suspended by any federal, state, or local government?

☐ Yes, attach explanation ☐ No

Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever been convicted under federal, state and/or local laws relating to drug samples and wholesale or retail drug distribution of controlled substances?

☐ Yes, attach 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 to the best of my knowledge, 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, and that the facility is currently licensed and in good standing in all states of licensure.

_____ _____

(Original Signature of Owner) (Original Signature of Pharmacist in Charge)

_____ _____

(Date) (Date)