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

Application For Non-Resident Pharmacy Permit

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Mail completed application to the above address. All applicable entries must be completed. Please use the checklist of required documentation at the end of this application. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Pharmacy Information:

Name of Pharmacy			
Physical Address of Pharmacy:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing Address of Pharmacy:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			

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Phone Number:
Fax Number:
Toll Free Number:
Website Address:

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

☐ **New Pharmacy** → **$150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

☐ **Change of Ownership** → **$150.00**

Proposed Date of Acquisition:
Name of Previous Owner(s):

(Must submit documentation detailing the specific ownership changes)

☐ **Change of Address/Location** → **$150.00**

Date of Proposed Relocation:

Previous Address:			
CITY:	STATE:	COUNTY:	ZIP:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Ownership:

How is the pharmacy registered with the Kentucky Secretary of State?

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ Not Applicable

★★please provide the following information for each owner/officer, including professional designation (e.g. Pres. John Jones, M.D.):

1.

Name:	Title:

Address(Business):			
CITY:	STATE:	COUNTY:	ZIP:

Address(Home):			
CITY:	STATE:	COUNTY:	ZIP:

Phone number(Business):

Phone number(Home):

Social Security Number:	Date of Birth:

2.

Name:	Title:

Address(Business):			
CITY:	STATE:	COUNTY:	ZIP:

Address(Home):			
CITY:	STATE:	COUNTY:	ZIP:

Phone number(Business):

Phone number(Home):

Social Security Number:	Date of Birth:

3.

Name:	Title:

Address(Business):			
CITY:	STATE:	COUNTY:	ZIP:

Address(Home):			
CITY:	STATE:	COUNTY:	ZIP:

Phone number(Business):

Phone number(Home):

Social Security Number:	Date of Birth:

4.

Name:	Title:

Address(Business):			
CITY:	STATE:	COUNTY:	ZIP:

Address(Home):			
CITY:	STATE:	COUNTY:	ZIP:

Phone number(Business):

Phone number(Home):

Social Security Number:	Date of Birth:

5.

Name:	Title:

Address(Business):			
CITY:	STATE:	COUNTY:	ZIP:

Address(Home):			
CITY:	STATE:	COUNTY:	ZIP:

Phone number(Business):

Phone number(Home):

Social Security Number:	Date of Birth:

(Use supplemental information page if necessary)

IV. Pharmacist-In-Charge (P.I.C.) :

P.I.C. :	KY License No.:

★★List the names and home state license numbers of any staff performing any function on a prescription for a KY patient:

Name:	License No. :
Name:	License No. :
Name:	License No. :

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Name:	License No. :
Name:	License No. :
Name:	License No. :

(Use supplemental information page if necessary)

Kentucky Pharmacy Regulation 201 KAR 2:205 requires pharmacists-in-charge to notify the Board within fourteen (14) calendar days of all pharmacist-in-charge and staff pharmacist changes.
KRS 315.0351 to require out-of-state pharmacies who are providing prescription medications to citizens of the Commonwealth to have a pharmacist-in-charge who holds a Kentucky pharmacist license. This Kentucky licensed pharmacist may be any employee pharmacist of the pharmacy.

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

Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:

(Use supplemental information page if necessary)

VI. Schedule of Hours:

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

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:

CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

KRS 315.0351 requires the pharmacy be open 6 days a week or provide documentation for on-call hours with a toll free telephone service directly to the pharmacist available to the patient.

VII. Does pharmacy currently utilize an automated data processing system?

☐ **YES***	☐ **NO**

***If yes:** identify the source for:

Hardware: ____________________

Software: ____________________

VIII. Types of Pharmacy (Check all that apply):

☐ **Retail Independent**	☐ **Retail Chain**	☐ **Infusion**
☐ **Nuclear**	☐ **Mail Order**	☐ **Nursing Home**
☐ **Internet***	☐ **Hospital**	☐ **Compounding**
☐ **Central Fill**	☐ **Oxygen**	☐ **Veterinary**

*This must be checked 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 checked, Section 9 must be completed.

IX. Does the pharmacy have a Digital Pharmacy accreditation or Healthcare Merchant (veterinary) accreditation?

☐ YES	☐ NO

X. Does the pharmacy dispense any prescriptions to citizens of the Commonwealth of Kentucky that have been referred to the pharmacy, in whole or in part, by an outside agent (e.g. internet broker)?

☐ YES*	☐ NO

If yes: Approximately how many anticipated or actual prescriptions dispensed to citizens of the Commonwealth of Kentucky per calendar month are referred to the pharmacy by agent(s).

:

★★List the name, address, phone number, and email address of all agents:

1.Name:			
Address:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			
Phone Number:			

2.Name:

Address:

CITY: STATE: COUNTY: ZIP:

Email Address:

Phone Number:

3.Name:

Address:

CITY: STATE: COUNTY: ZIP:

Email Address:

Phone Number:

4.Name:

Address:

CITY: STATE: COUNTY: ZIP:

Email Address:

Phone Number:

5. Name:
Address:
CITY: STATE: COUNTY: ZIP:
Email Address:
Phone Number:

(Use supplemental information page if necessary)

XI. Does the pharmacy employ, contract with, or compensate directly or indirectly physicians to authorize prescriptions for citizens of the Commonwealth of Kentucky?

☐ **YES***	☐ **NO**

***If yes:** please provide the following information for all physicians:

1. Name:
Business Address:
CITY: STATE: COUNTY: ZIP:
Business Phone:

Email Address:

DEA Number:	State(s) of licensure:
Social Security Number:	Date of Birth:

2.Name:

Business Address:

CITY:	STATE:	COUNTY:	ZIP:

Business Phone:

Email Address:

DEA Number:	State(s) of licensure:
Social Security Number:	Date of Birth:

3.Name:

Business Address:

CITY:	STATE:	COUNTY:	ZIP:

Business Phone:

Email Address:	
DEA Number:	State(s) of licensure:
Social Security Number:	Date of Birth:

4. Name:			
Business Address:			
CITY:	STATE:	COUNTY:	ZIP:
Business Phone:			
Email Address:			
DEA Number:	State(s) of licensure:		
Social Security Number:	Date of Birth:		

5. Name:			
Business Address:			
CITY:	STATE:	COUNTY:	ZIP:
Business Phone:			

Email Address:	
DEA Number:	State(s) of licensure:
Social Security Number:	Date of Birth:

(Use supplemental information page if necessary)

XII. Does the pharmacy ship any prescriptions to the citizens of the Commonwealth of Kentucky under any name or return address other than the information of the pharmacy seeking or renewing a permit provided with this application?

☐ YES*	☐ NO

If yes: Please provide a list of the additional pharmacy name(s) or return addresses that the pharmacy ships prescriptions to citizens of the Commonwealth of Kentucky and why.

____

____

____

____

____

(Use supplemental information page if necessary)

XIII. List the methods of deliver services (e.g. USPS, UPS, FedEx, etc) utilized to deliver prescriptions to citizens of the Commonwealth of

Kentucky and the percentage of time each service is utilized in Kentucky.

Delivery Service Utilized:	Percentage of Time:

(Use supplemental information page if necessary)

XIV. Are you permitted in other states?

☐ YES*	☐ NO

*If yes: please list below

:

XV. Has the pharmacy or pharmacist in charge been subject to discipline in any jurisdiction? If so, please provide the state, case number and summary of discipline assessed.

☐ YES*	☐ NO

*If yes: please attach statement

XVI. Has the pharmacy shipped drugs into Kentucky prior to obtaining a permit?

☐ **YES**	☐ **NO**

XVII. Do you perform sterile compounding?

☐ **YES**	☐ **NO**

XVIII. Do you perform nonsterile compounding?

☐ **YES**	☐ **NO**

XIX. Does this pharmacy stock any emergency medication kits?

☐ **YES**	☐ **NO**

XX. Does this pharmacy stock any long term care facility in Kentucky?

☐ **YES**	☐ **NO**

XXI. Does this pharmacy utilize any automation for prescription dispensing?

☐ YES	☐ NO

XXII. Date of last controlled substance inventory:

Date:

Supplemental Information Page:

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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 Pharmacist-in-Charge: ______________________ **Date:** __________

I hereby certify that the above Application for Resident Pharmacy Permit was signed, subscribed and sworn to before me this _________day of ___________, 20______.

By: ______________________________

Signature: ______________________________

My Commission Expires ______________________ State of ___________________.

Signature of Owner: ______________________ **Date:** __________

I hereby certify that the above Application for Resident Pharmacy Permit was signed, subscribed and sworn to before me this __________day of _____________, 20_______.

By: ______________________________

Signature: ______________________________

My Commission Expires ______________________ State of ___________________.

REQUIRED DOCUMENTATION MUST BE ENCLOSED:

- ☐ Completed application
- ☐ Copy of Resident Pharmacy Permit
- ☐ Copy of Last Inspection Report
- ☐ Copy of DEA Registration
- ☐ Completed Attached License Verification Form or Primary Source Verification Form
- ☐ Sample Pharmacy Labels for Controlled and Non-Controlled Substances shipped into Kentucky
- ☐ Copy of the End-of-Day Report for the Seven (7) Business Days preceding the application date
- ☐ Copy of notarized *Memorandum of Understanding and Agreement*