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 Special Limited Pharmacy Permit ⇨ Charitable Pharmacy Renewal

Enclose a check or money order for $150.00, made payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Please print legibly and complete this application; including the required original signature and return no later than June 30th.

I. Facility Information:

Name of Facility:			
Kentucky Permit No.:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			
Phone Number:			
Fax Number:			

Website Address:

II. Ownership:

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

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ N/A

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

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

(Use supplemental information page if necessary)

III. 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:
☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS

★Please indicate if closed for lunch:

_____ until _____

EMPLOYEE INFORMATION:

1. Pharmacist in Charge (P.I.C.):

Name:	License No.:

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

2. Please provide a complete list of all employees licensed/registered with the Board:

Name:	License/Registration Number (Pharmacist, Pharmacist Intern or Pharmacy Technician):
1.	
2.	
3.	
4.	

5.	
6.	
7.	
8.	
9.	
10.	

(Use supplemental information page if necessary)

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

Name:		Title:	
Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:		Title:	
Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary)

IV. Discipline:

Have you had a Pharmacy license/permit disciplined by any agency which you have not previously reported to this Board?

☐ **YES***	☐ **NO**

If yes: Please explain below

:

V. 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)

VI. 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)

VII. Are you permitted in other states?

☐ YES*	☐ NO

If yes: please list below

:

Supplemental Information Page:

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 Pharmacist-in-Charge: **Date:**

I hereby certify that the above Application for Non-Resident Special Limit Pharmacy Permit was signed, subscribed and sworn to before me this _____day of _____, 20_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Original Signature of Owner: **Date:**

I hereby certify that the above Application for Non-Resident Special Limited Pharmacy Permit was signed, subscribed and sworn to before me this _____day of _____, 20_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Form 9/2023