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 Renewal

Please print legibly. Make check or money order for $150, made payable to 'Kentucky State Treasurer' Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Mail completed application including the required original signatures and mail to the above address. All applications must be received in the Board office by June 30th.

I. Pharmacy Information:

Name of Pharmacy			
Kentucky Permit Number:			
Physical Address of Pharmacy:			
CITY:	STATE:	COUNTY:	ZIP:
Email:			

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Phone number:			
Fax number:			
Toll Free Number:			
Website Address:			
Date of last controlled substance inventory:			
Mailing Address of Pharmacy:			
CITY:	STATE:	COUNTY:	ZIP:
DEA Registration No.:		Exp. Date:	

II. Ownership:

How are you registered with the Kentucky Secretary of State?

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

★★ Name and title for each owner/officer/member, including office and professional designation:

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1.

Name:	Title:

2.

Name:	Title:

3.

Name:	Title:

4.

Name:	Title:

5.

Name:	Title:

(Use supplemental information page if necessary)

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

P.I.C. :	KY License No.:
City of Residence:	

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 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.

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

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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)

V. 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.

VI. List the names and resident state license numbers of any staff pharmacist performing any function on a prescription for a KY patient:

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

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Name: License No. :

(Use supplemental information page if necessary)

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

☐ **Retail Independent**	☐ **Retail Chain**	☐ **Infusion**
☐ **Nuclear**	☐ **Mail Order**	☐ **Nursing Home**
☐ **Internet***	☐ **Hospital**	☐ **Central Fill**
☐ **Compounding**	☐ **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, digital pharmacy accreditation will be verified with the NABP and Section 8 must be completed.

VIII. 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:

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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:			

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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)

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

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☐ 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: (optional)	Date of Birth:

2.Name:	
Business Address:	
CITY: STATE: COUNTY: ZIP:	
Business Phone:	
Email Address:	

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

3.Name:
Business Address:
CITY: STATE: COUNTY: ZIP:
Business Phone:
Email Address:

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

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

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

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

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

(Use supplemental information page if necessary)

X. 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?

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☐ 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)

XI. Do you perform sterile compounding?

☐ YES	☐ NO

XII. Do you perform non-sterile compounding?

☐ YES	☐ NO

XIII. Are you permitted in other states?

☐ YES*	☐ NO

If yes: Please list below

:

XIV. Have you had a Pharmacy license/permit disciplined by any other agency or has your PIC been disciplined by any other agency which you have not previously reported to this Board?

☐ **YES***	☐ **NO**

If yes: Please explain below

:

XV. List the names and resident state license numbers of any staff pharmacist performing any function on a prescription for a KY patient:

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

(Use supplemental information page if necessary)

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XVI. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

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

☐ YES	☐ NO

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

☐ YES*	☐ NO

If yes: Please explain below

:

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Supplemental Information Page:

PLEASE INCLUDE A COPY OF YOUR MOST RECENT PHARMACY INSPECTION WITH THIS APPLICATION

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 Renewal Application for Non-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 Renewal Application for Non-Resident Pharmacy Permit was signed, subscribed and sworn to before me this _____day of _____, 20_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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