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 Resident 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. All renewals received after June 30th will be assessed a delinquent fee of $150.00 pursuant to 201 KAR 2:050, Section 1(10).

INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED

I. Pharmacy Information:

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

Phone Number:
Fax Number:
Website Address:
Date of last controlled substance inventory:

DEA Registration No.:	Exp. Date:

II. Ownership:

How are you registered with the Kentucky Secretary of State?

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ Corporation
- ☐ LLC
- ☐ Other

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

1.

Name:	Title:

2.

Name:	Title:

3.

Name:	Title:

4.

Name:	Title:

5.

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 _____

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

- ☐ **Retail Independent**
- ☐ **Retail Chain**
- ☐ **Infusion**
- ☐ **Nuclear**
- ☐ **Mail Order**
- ☐ **Nursing Home**
- ☐ **Internet***
- ☐ **Hospital**
- ☐ **Hospital-Ambulatory**
- ☐ **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.

V. Does pharmacy ship medications outside of Kentucky?

☐ **YES**	☐ **NO**

VI. Do you perform sterile compounding?

☐ **YES**	☐ **NO**

VII. Do you perform non-sterile compounding?

☐ **YES**	☐ **NO**

VIII. Are you permitted in other states?

☐ **YES**	☐ **NO**

If yes: Please list below

:

IX. 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

:

X. For institutional pharmacies, are there decentralized pharmacy services (i.e. oncology satellite, OR satellite, etc.) where drugs are prepared, stored, and/or compounded in the facility?

☐ YES*	☐ NO

If yes: how many?

:

XI. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

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

☐ YES	☐ NO

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

☐ YES*	☐ NO

If yes: Please explain below

:

EMPLOYEE INFORMATION:

1. 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.

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)

4. **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):**

Name:	Affiliation:
Address:	
CITY: STATE: COUNTY: ZIP:	

Name:	Affiliation:
Address:	
CITY: STATE: COUNTY: ZIP:	

Name:	Affiliation:
Address:	
CITY: STATE: COUNTY: ZIP:	

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary

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 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:**

I hereby certify that the above Renewal 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 Pharmacist-in-Charge: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.