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 Permit To Operate A Pharmacy In Kentucky

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal
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.

I. Pharmacy Information:

Name of Pharmacy:
Physical Address of Pharmacy:
CITY: STATE: COUNTY: ZIP:
Email:
Phone number:

Fax number:
Website Address:
Mailing Address of Pharmacy:
CITY: STATE: COUNTY: ZIP:

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

☐ **New Facility** → **$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):

(Please include detailed explanation of the change, including type of transaction, date of transaction and structure of the transfer)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Ownership:

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

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

★★ Name and title for each owner/officer/member, including office and professional designation *(e.g. Pres. John Jones, M.D.)* :

1.

Name:	Title:

2.

Name:	Title:

3.

Name:	Title:

4.

Name:	Title:

5.

Name:	Title:

(Use supplemental information page if necessary)

IV. Has any owner , member or officer been subject to discipline by any other agency related to the ownership or employment in a pharmacy?

☐ **YES***	☐ **NO**

If yes: Please explain below

:

V. Pharmacist-In-Charge (P.I.C.), Pharmacist(s), Interns and Technicians :

Name	KY License No.:	P.O.A.	Key
P.I.C. :		☐	☐
		☐	☐
		☐	☐

		☐	☐
		☐	☐

(Use supplemental information page if necessary)

(Please indicate by checking the space provided those who have "Power of Attorney" (P.O.A) to order Controlled Substances and/or have been issued keys to the pharmacy.)

Kentucky Pharmacy Regulation 201 KAR 2:205 requires pharmacists-in-charge to notify the Board of all pharmacist personnel changes and changes in pharmacy operating hours.

VI. 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)

VII. 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:

★Please indicate if closed for lunch:

_____ until _____

VIII. Name, address and affiliation of all individuals, other than those previously identified in this application, responsible for pharmacy management or staffing (e.g., 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)

IX. Type of Pharmacy (Check all that apply) :

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

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

☐ YES*	☐ NO

*If yes: identify the source for:

Hardware: _____

Software: _____

XI.Does the pharmacy plan on obtaining a Digital Pharmacy accreditation or Healthcare Merchant (veterinary) accreditation?

☐ YES	☐ NO

XII. Do you plan on performing sterile compounding?

☐ YES	☐ NO

XIII. Do you plan on performing non-sterile compounding?

☐ YES	☐ NO

XIV. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

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

☐ YES	☐ NO

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

☐ YES	☐ NO

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 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 _____.