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 or Third Party Logistics Provider License Renewal

Enclose a check or money order for $400.00, made payable to 'Kentucky State Treasurer' or payment can be made online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal. Please print legibly and complete this application; including the required original signature and return to the Board office no later than June 30th.

I. Facility Information:

Facility Name:

Address:

CITY: STATE: COUNTY: ZIP:

Email Address:

Website Address:

Phone Number:

TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY

Fax Number:

II. Ownership:

How is this facility registered with the Secretary of State?

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

★★ Please provide the following information for each owner/partner/director/member/officer:

1.

Name:	Title:
Email:	
Phone number(Business):	
Phone number(Home):	
Social Security Number:	Date of Birth:
Federal Employee ID Number:	
Address(Home):	

CITY:	STATE:	COUNTY:	ZIP:

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

2.

Name:	Title:

Email:

Phone number(Business):

Phone number(Home):

Social Security Number:	Date of Birth:

Federal Employee ID Number:

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

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

3.

Name:	Title:
Email:	
Phone number(Business):	
Phone number(Home):	
Social Security Number:	Date of Birth:
Federal Employee ID Number:	
Address(Home):	

CITY:	STATE:	COUNTY:	ZIP:

Address(Business):

CITY:	STATE:	COUNTY:	ZIP:

4.

Name:	Title:
Email:	
Phone number(Business):	

Phone number(Home):

Social Security Number:	Date of Birth:

Federal Employee ID Number:

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

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

5.

Name:	Title:

Email:

Phone number(Business):

Phone number(Home):

Social Security Number:	Date of Birth:

Federal Employee ID Number:

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

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

(Use supplemental information page if necessary)

III. Schedule of Hours:

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

IV. Registration Numbers and Expiration Dates:

DEA:	Exp. Date:

FDA:	Exp. Date:

V. Name, phone, and email of the Facility Contact Person:

Name:
Title:
Phone Number:
Email:

VI. Qualifying Questions:

1. **Have any owner [s], partner [s], officer [s], or agent been convicted of any felony under federal, state, and/or local laws that has not been previously reported to the Board?**

☐ **YES***	☐ **NO**

****If yes:*** please provide explanation below:

Explanation:

2. **Has any owner [s], partner [s], officer [s] or agent had a license or permit related to drugs disciplined by any federal, state, or local government that was not previously reported to the Board?**

☐ **YES***	☐ **NO**

****If yes:*** please provide explanation below:

Explanation:

3. **What was the date of the last facility inspection?**

Date:

*If performed by an entity other than the Kentucky Board of Pharmacy, please provide a copy of the inspection report.

Supplemental Information Page:

TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY

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. If the registration herein applied for is granted, I certify that this business will be conducted in full compliance with all applicable federal and state laws and that I will make available any or all records required by law to the extent authorized by law.

Signature of Owner: ______________________________ **Date:** __________

I hereby certify that the above Renewal Application to Operate as a Third Party Logistics Provider was signed, subscribed and sworn to before me this ________day of ____________, 20________.

By: ______________________________

Signature: ______________________________

My Commission Expires ____________________ State of ____________.

TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY