

**KENTUCKY BOARD OF PHARMACY**  
**State Office Building Annex, Suite 300**  
**125 Holmes Street**  
**Frankfort KY 40601**  
**Phone (502) 564-7910      Fax (502) 696-3806**

**Application For Non-Resident Pharmacy Permit Renewal**

Please print legibly. Make check or money order for \$100 made payable to 'Kentucky State Treasurer'. 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 30<sup>th</sup>.

**1. Name of Pharmacy** \_\_\_\_\_

**Physical Address of Pharmacy** \_\_\_\_\_  
(Street and Number)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Toll Free Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Website Address \_\_\_\_\_ Email Address \_\_\_\_\_

**Mailing Address of Pharmacy** \_\_\_\_\_  
(Street and Number)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED.**

DEA Registration No. \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Ownership:**

Sole Proprietor       Partnership       Corporation       LLC       Other

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**2. Pharmacist-In-Charge (P.I.C.):**

Name	Kentucky License No.	City of Residence
P.I.C. _____	_____	_____

List the names, license numbers, and cities of residence of all staff pharmacists: (Use a separate piece of paper if necessary)

Name	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 and staff pharmacist changes.

**Senate Bill 88 amends 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.**

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

\_\_\_\_\_

\_\_\_\_\_

**4. Schedule of Hours:** \*\*P.I.C. must notify the Board within fourteen (14) days of any changes in scheduled hours.

Monday . . . \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M. Thursday . . . \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M. Sunday . . . \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M.  
 Tuesday . . . \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M. Friday . . . \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M.  
 Wednesday . . . \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M. Saturday . . . \_\_\_\_\_ A.M. to \_\_\_\_\_ P.M.

**5. Does pharmacy currently utilize an automated data processing system?** \_\_\_\_\_ Yes\* \_\_\_\_\_ No

\*If yes, identify the source for: hardware \_\_\_\_\_ software \_\_\_\_\_

**6. TYPES OF PHARMACY (INDICATE BY CIRCLING ALL THAT APPLY):**

Retail Independent      Retail Chain      Hospital      Nursing Home      Nuclear  
 \* Internet      Mail Order      Infusion      Out-of-State      Oxygen

**\* This must be circled 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 circled, VIPPS accreditation will be verified with the NABP and Section 7 must be completed.**

**7. 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:

NAME	ADDRESS	PHONE NUMBER	EMAIL ADDRESS
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(Use a separate piece of paper if necessary)

**Does the pharmacy employ, contract with, or compensate directly or indirectly physicians to authorize prescriptions for citizens of the Commonwealth of Kentucky?** \_\_\_\_\_ Yes\* \_\_\_\_\_ No

\*If yes: On a separate sheet of paper, please provide the following information for all physicians:

- ◆ Name
- ◆ Business Address
- ◆ Business Phone
- ◆ Email address
- ◆ DEA number
- ◆ State(s) of licensure
- ◆ Date of Birth
- ◆ Social Security number [optional]

**8. 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 a separate piece of paper if necessary)

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**9. List the methods of deliver services (e.g. USPS, UPS, DHL, 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 Utilized
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(Use a separate piece of paper if necessary)

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