

**KENTUCKY BOARD OF PHARMACY**  
**State Office Building Annex, Suite 300**  
**125 Holmes Street**  
**Frankfort KY 40601**  
**Phone (502) 564-7910**  
**Fax (502) 696-3806**  
**e-mail: [pharmacy.board@ky.gov](mailto:pharmacy.board@ky.gov)**  
**<http://pharmacy.ky.gov>**

**Application For Non-Resident Pharmacy Permit**

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer'. Mail completed application to the above address. All applicable entries must be completed. Please use the checklist of required documentation at the end of this application. Incomplete applications will be returned. Each permit expires June 30<sup>th</sup> following the date of issuance.

**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 \_\_\_\_\_

**Check and complete one of the following and attach proper fee:**

- New Pharmacy ..... \$100.00  
Proposed date of Opening \_\_\_\_\_  
(Filed with Board 30 days in advance of Opening)
- Change of Ownership ..... \$75.00  
Date of Proposed Acquisition \_\_\_\_\_  
Name of Previous Owner(s) \_\_\_\_\_  
(Confirmation statement of previous owner must be attached)
- Change of Address/Location ..... \$75.00  
Date of Proposed Relocation \_\_\_\_\_  
Previous Address \_\_\_\_\_
- Name Change ..... \$5.00  
Previous Name \_\_\_\_\_

**2. Ownership:**

- Sole Proprietor  
  Partnership  
  Unincorporated Business  
  Incorporated Business  
  Other

On a separate sheet of paper, please provide the following information for each owner/officer, including professional designation (e.g. Pres. John Jones, M.D.):

- ❖ Name and Title
- ❖ Address (Business and Home)
- ❖ Phone Number (Business and Home)
- ❖ Social Security Number
- ❖ Date of Birth

**3. 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:

Name	License No.	City of Residence
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Use a separate piece of paper if necessary)

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.**

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

\_\_\_\_\_

\_\_\_\_\_

**5. Schedule of Hours:**

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

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

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

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

**7. 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. Section 8 must be completed.

**8. Is the pharmacy VIPPS accredited?** \_\_\_\_\_Yes \_\_\_\_\_No

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]

**9. 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.

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(Use a separate piece of paper if necessary)

10. 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
_____	_____
_____	_____
_____	_____
_____	_____

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 Pharmacist-in-Charge

\_\_\_\_\_  
Date

I hereby certify that the above **Application for Non-Resident Pharmacy Permit** was signed, subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Signature\_\_\_\_\_

My Commission Expires\_\_\_\_\_ State of \_\_\_\_\_

\_\_\_\_\_  
Signature of Owner

\_\_\_\_\_  
Date

I hereby certify that the above **Application for Non-Resident Pharmacy Permit** was signed, subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Signature\_\_\_\_\_

My Commission Expires\_\_\_\_\_ State of \_\_\_\_\_

**REQUIRED DOCUMENTATION MUST BE ENCLOSED:**

- Completed application
- Copy of Resident Pharmacy Permit
- Copy of Last Inspection Report
- Copy of DEA Registration
- Completed Attached License Verification Form
- Sample Label of any Pharmacy Label used to ship Controlled and Non-Controlled Substances into Kentucky
- Copy of the End-of-Day Report for the Seven (7) Business Days preceding the application date
- Copy of notarized *Memorandum of Understanding and Agreement*

**KENTUCKY BOARD OF PHARMACY**  
**State Office Building Annex, Suite 300**  
**125 Holmes Street**  
**Frankfort KY 40601**

*Memorandum of Understanding and Agreement*

I have read, understand, and agree to abide by KRS Chapters 315, 217, and 218A; 201 KAR Chapter 2; and 902 KAR Chapter 55. In addition, I specifically acknowledge and agree to the following:

I understand that the Board of Pharmacy ("board") may refuse to issue or renew a license or permit, or may suspend, temporarily suspend, revoke, fine, place on probation, reprimand, reasonably restrict, or take any combination of actions against a licensee or permit holder for knowingly making or causing to be made any false, fraudulent, or forged statement or misrepresentation of a material fact in securing issuance or renewal of a license or permit. **KRS 315.121(1) (e)**

Every out-of-state pharmacy granted an out-of-state pharmacy permit by the board shall disclose to the board the location, names and titles of all principal corporate officers and all pharmacists who are dispensing prescription drugs to residents of the Commonwealth. A report containing this information shall be made to the board on an annual basis and within thirty (30) days after any change of office, corporate officer, or pharmacist. **KRS 315.0351(2)**

The pharmacist-in-charge shall be responsible for providing written notification to the board within fourteen (14) days of any change in the employment of the pharmacist-in-charge, staff pharmacists, and pharmacy hours. **201 KAR 2:205, Section 2(3)(d)**

The out-of-state pharmacy shall maintain at all times a valid unexpired permit, license, or registration to conduct the pharmacy in compliance with the laws of the jurisdiction in which it is a resident. **KRS 315.0351(3)**

The out-of-state pharmacy granted a permit shall submit to the board a copy of any subsequent inspection report on the pharmacy conducted by the regulatory or licensure body of the jurisdiction in which it is located. **KRS 315.0351(3)**

Every out-of-state pharmacy granted an out-of-state pharmacy permit shall maintain records of any controlled substances or dangerous drugs or devices dispensed to patients in Kentucky so that the records are readily retrievable from the records of other drugs dispensed. **KRS 315.0351(4)**

Records for all prescriptions delivered into Kentucky shall be readily retrievable from the other prescription records of the out-of-state pharmacy. **KRS 315.0351(5)**

Each out-of-state pharmacy shall, during its regular hours of operation, but not less than six (6) days per week and for a minimum of forty (40) hours per week, provide a toll-free telephone service directly to the pharmacist in charge of the out-of-state pharmacy and available to both the patient and each licensed and practicing in-state pharmacist for the purpose of facilitating communication between the patient and the Kentucky pharmacist with access to the patient's prescription records. The toll-free number shall be placed on a label affixed to each container of drugs dispensed to patients within Kentucky. **KRS 315.0351(6)**

Each out-of-state pharmacy shall have a pharmacist in charge who is licensed to engage in the practice of pharmacy in Kentucky that shall be responsible for compliance by the pharmacy. **KRS 315.0351(7)**

Each out-of-state pharmacy shall comply with KRS 218A.202:

- Every dispenser who is licensed by the Kentucky Board of Pharmacy shall report required data to the Cabinet for Health Services in a timely manner. **KRS 218A.202(3)**
- Data for each controlled substance shall include but not be limited to patient identifier, drug dispensed, date of dispensing, quantity dispensed, prescriber, and dispenser. **KRS 218A.202(4)**
- The data shall be provided in the electronic format specified by the Cabinet for Health Services unless a waiver has been granted by the cabinet to an individual dispenser. **KRS 218A.202(5)**
- Knowing failure by a dispenser to transmit data to the cabinet as required shall be a Class A misdemeanor. **KRS 218A.202(9)**

Any out-of-state pharmacy doing business, primarily or exclusively by use of the Internet shall, prior to obtaining a permit, receive and display in every medium in which it advertises itself a seal of approval for the National Association of Boards of Pharmacy certifying that it is a Verified Internet Pharmacy Practice Site (VIPPS). VIPPS certification shall be maintained and remain current. **KRS 315.0351(9)**

Any out-of-state pharmacy doing business primarily or exclusively by use of the Internet shall certify the percentage of its annual business conducted via the Internet and submit such supporting documentation as requested by the board, and in a form or application required by the board, when it applies for permit or renewal. **KRS 315.0351(10)**

I hereby certify that I have read and agree to abide by the provisions referenced within this *Memorandum of Understanding and Agreement*.

\_\_\_\_\_  
Signature of Pharmacist-in-Charge \_\_\_\_\_ Date

I hereby certify that the above *Memorandum of Understanding and Agreement* was signed, subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Signature \_\_\_\_\_

My Commission Expires \_\_\_\_\_ State of \_\_\_\_\_

\_\_\_\_\_  
Signature of Owner \_\_\_\_\_ Date

I hereby certify that the above *Memorandum of Understanding and Agreement* was signed, subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

Signature \_\_\_\_\_

My Commission Expires \_\_\_\_\_ State of \_\_\_\_\_



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**NON-RESIDENT PHARMACY PERMIT VERIFICATION**

This form must be completed by the applicant and the Board of Pharmacy of the state in which the applicant is located, and returned with the non-resident pharmacy permit application to the Board office before a non-resident pharmacy permit will be issued.

Name of Pharmacy		
Physical Address of Pharmacy		
City	State	ZIP Code
Name of Pharmacist-in-Charge	License Number	
<b>The following section is to be completed by the Board of Pharmacy of the state in which the applicant is located:</b>		
<p>Is the pharmacy properly licensed or registered in your state? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>Has this pharmacy been the subject of disciplinary action(s) taken by any licensing jurisdiction, government agency, law enforcement agency or court? <span style="float: right;"><input type="checkbox"/> Yes* <input type="checkbox"/> No</span></p> <p><b>*If yes, attach a letter of explanation, a copy of the charging document/complaint and all relevant court documents.</b></p> <p>Has the Pharmacist-in-Charge been the subject of disciplinary action(s) taken by any licensing jurisdiction, government agency, law enforcement agency or court? <span style="float: right;"><input type="checkbox"/> Yes* <input type="checkbox"/> No</span></p> <p><b>*If yes, attach a letter of explanation, a copy of the charging document/complaint and all relevant court documents.</b></p>		
Printed name and title of State Official	State	
Signature of State Official	Date	
<b>SEAL</b>		

