

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 RESIDENT PHARMACY RENEWAL
INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED.

Enclose a check or money order for \$100.00, made payable to 'Kentucky State Treasurer'. Please print legibly and complete this application; including the required original signature and return no later than June 30th.

◆ Pharmacy Name _____ Permit No. _____
Address _____ Telephone No. _____
_____ Fax Number _____

◆ DEA Registration No. _____ Expiration Date: _____ Date of last controlled substance inventory _____

◆ Ownership:
 Sole Proprietor Partnership Corporation LLC Other

Name and title for each owner/officer, including office and professional designation: (Use a separate piece of paper if necessary)

◆ Pharmacist-In-Charge(PIC) and Registered Pharmacist(s):

	Name	KY License No.	POA	Key
PIC:	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

[Please indicate by checking the space provided those who have "Power of Attorney" (POA) to order controlled substances and those who have keys to the pharmacy.]
Note: 201 KAR 2:205 requires the pharmacist-in-charge to notify the Board within fourteen [14] calendar days of all pharmacist changes.

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

◆ 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. Please indicate if closed for lunch. _____

◆ 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) on a separate sheet of paper.

◆ Does pharmacy currently utilize an automated data processing system? Yes _____ No _____
If yes, identify the: hardware _____ software _____

◆ Type 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.

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