

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 to Operate as a Wholesale Distributor or Manufacturer

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer'. Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each license/permit expires September 30th following the date of issuance.

1. Name of Facility _____

Physical Address of Facility _____

City _____ State _____ County _____ Zip _____
(Street and Number)

Phone Number _____ Fax Number _____

Mailing Address of Facility _____

City _____ State _____ Zip _____
(Street and Number)

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

New Wholesaler \$100.00
Proposed date of Opening _____
(Filed with Board 30 days in advance of Opening)

New Manufacturer* \$100.00
Proposed date of Opening _____
(Filed with Board 30 days in advance of Opening)

***[Manufacturer permit is issued to resident facilities only.]**

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 _____

Registration Numbers and Expiration Dates:

DEA: _____ Exp. Date: ____/____/____

FDA: _____ Exp. Date: ____/____/____

CHFS: _____ Exp. Date: ____/____/____

(KY Controlled Substances License)

2. Name and title of facility contact person:

Name: _____

Extension: _____

3. Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever been convicted of any felony under federal, state, and/or local laws?

Yes, attach explanation No

Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever has a wholesale distributor license/permit revoked or suspended by any federal, state, or local government?

Yes, attach explanation No

Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever been convicted under federal, state and/or local laws relating to drug samples and wholesale or retail drug distribution of controlled substances?

Yes, attach explanation No

4. 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.

5. If operations include drug manufacturing [for resident facilities only], identify the Pharmacist-in-Charge:

Name: _____ License No: _____

6. Ownership:

Sole Proprietor Partnership Unincorporated Business Incorporated Business Other

Pursuant to 201 KAR 2:105, Section 4, 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

7. Is this facility VAWD accredited? _____ Yes, please provide number _____ No

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/Officer and Title)

_____/_____/_____
(Date)

I hereby certify that the above Application for Wholesale Distributor or Manufacturer was signed, subscribed and sworn to before me this _____ day of _____, 20____.

My Commission Expires _____ State of _____

Signature _____

REQUIRED DOCUMENTATION FOR NON-RESIDENT FACILITIES MUST BE ENCLOSED:

- Completed application
- Copy of Resident Permit
- Copy of Last Inspection Report
- Copy of DEA Registration
- Completed Attached License Verification Form

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NON-RESIDENT WHOLESALE DISTRIBUTOR 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 wholesale distributor application to the Board office before a non-resident wholesale distributor license will be issued.

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

