

**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 Special-Medicinal Gas Permit**

*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 permit expires June 30th following the date of issuance.*

1. Name of Facility \_\_\_\_\_

Physical Address of Facility \_\_\_\_\_  
(Street and Number)

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

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Mailing Address of Facility \_\_\_\_\_  
(Street and Number)

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

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

New Facility ..... \$100.00

Proposed date of Opening \_\_\_\_\_  
(Filed with Board 30 days in advance of Opening) OR Current Permit No. \_\_\_\_\_ Expiration Date \_\_\_\_\_  
(In State where presently located)

Renewal ..... \$100.00

(Late Renewal Fee after June 30 . . . \$175)

Current Kentucky Permit No. \_\_\_\_\_

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

Name and title for each owner/officer, including professional designation (e.g. Pres. John Jones, PharmD)

\_\_\_\_\_



**3. Consultant Pharmacist:**

Name

KY License No.

\_\_\_\_\_

\_\_\_\_\_

Kentucky Pharmacy Regulation 201 KAR 2:205 requires Consultant Pharmacist to notify the Board within fourteen (14) calendar days of all pharmacist personnel changes.

**Pharmacist Consultants are not required for non-resident medicinal gas permits.**

**4. Schedule of Hours:**

Monday . . \_\_\_\_\_ AM to \_\_\_\_\_ PM

Friday . . \_\_\_\_\_ AM to \_\_\_\_\_ PM

Tuesday . . \_\_\_\_\_ AM to \_\_\_\_\_ PM

Saturday . \_\_\_\_\_ AM to \_\_\_\_\_ PM

Wednesday . \_\_\_\_\_ AM to \_\_\_\_\_ PM

Sunday . . \_\_\_\_\_ AM to \_\_\_\_\_ PM

Thursday . . . \_\_\_\_\_ AM to \_\_\_\_\_ PM

Consultant Pharmacist must notify the Board within fourteen (14) days of any changes in scheduled hours.

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, 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, and that the facility is currently licensed and in good standing in all states of licensure.*

\_\_\_\_\_  
(Original Signature of Owner)

\_\_\_\_\_  
(Original Signature of Consultant Pharmacist)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Date)