

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 an Outsourcer Facility

Print legibly. Make check or money order payable to Kentucky State Treasurer. Mail completed notarized application to the above address with required documentation. Incomplete applications will be returned. Licenses expire June 30 following date of issuance.

1. Name of Facility _____

Physical Address of Facility _____

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

Phone Number _____ Email address _____

Mailing Address of Facility _____

City _____ State _____ Zip _____
(Street and Number)

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

New Outsourcer \$250.00
Proposed date of Opening _____

Renewal (add \$250 for each year delinquent). \$250.00

Ownership Change \$100.00

Date of Proposed Acquisition _____

Name of Previous Owner(s) _____

(Confirmation statement of previous owner must be attached)

Change of Address/Location \$100.00

Date of Proposed Relocation _____

Previous Address _____

Name Change NO CHARGE

(Attach legal proof)

Previous Name _____

2. Registration Numbers and Expiration Dates

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

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

3. Pharmacist-In-Charge:

Name: _____

Pharmacist License No.: _____

Address: _____

Email: _____

4. **Has applicant, owner, officer, or pharmacist-in-charge ever been convicted of a felony of federal, state, drug law, or medical assistance program?**
 Yes, attach explanation No
- Has applicant, owner, officer, or pharmacist-in-charge ever had a professional license or permit disciplined by federal, state, or local law?**
 Yes, attach explanation No
- Has applicant, owner, officer, or pharmacist-in-charge ever applied for a license with this Board?**
 Yes, include license or permit number No

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.	

6. **Ownership:**

- Sole Proprietor Partnership Unincorporated Business Incorporated Business Other

On a separate sheet of paper, please provide the following information for each owner or officer:

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

Pursuant to KRS 315.121, the Board may refuse to issue or otherwise discipline any licensee or permit holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a permit.

I hereby certify that the foregoing is true and correct to the best of my knowledge. If the license 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)

NOTARY INFORMATION - I hereby certify that the above **Application for License to Operate as an Outsourcer (503b) Facility** was signed, subscribed and sworn to before me this _____ day of _____, 20____.

My Commission Expires _____ State of _____

Signature _____

REQUIRED DOCUMENTATION:

[Only required with initial application and updates as necessary]

- Completed application
- Correct Fee
- Copy of Current Inspection Report by FDA, NABP or Board
- Copy of FDA Outsourcing Facility Registration
- Copy of DEA Registration
- Confirmation Statement of former owner for Section 1
- Legal proof of name change for Section 1
- Explanations for Section 4
- Ownership information for Section 6