

Kentucky Permit Number

CP _____

**DON'T
FORGET!**

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
<http://pharmacy.ky.gov>

Application for 'Special Pharmacy Permit for Clinical Practice' Renewal

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. All renewals received after June 30, 2012 will be assessed a delinquent fee of \$75.00 pursuant to 201 KAR 2:050, Section 1(11).

1. Name of Facility _____

Physical Address of Facility _____
(Street and Number)

City _____ County _____ State _____ Zip _____

Phone Number _____ Fax Number _____

Email Address _____

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. **Pharmacist in Charge:**

Name _____ KY License No. _____

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

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 Pharmacist in Charge)

(Date)

(Date)