KENTUCKY BOARD OF PHARMACY
State Office Building Annex,Suite 300
125 Holmes Street
Frankfort KY 40601
Phone:(502) 564-7910
Fax:(502) 696-3806
Email: pharmacy.board@ky.gov
http://pharmacy.ky.gov

Application for Nonresident Special Limited Pharmacy Permit ⇨ Medical Gas

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . 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.

I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing address of facility:			
CITY:	STATE:	COUNTY:	ZIP:

Email:
Phone number:
Fax number:
Website Address:

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

☐ **New Facility → $150.00**

Current Permit No. :	Exp. Date:

(In State where presently located)

☐ **Change of Ownership → $150.00**

Proposed date of Acquisition:
Name of Previous Owner(s):

(Confirmation statement of previous owner must be attached)

☐ **Change of Address/Location → $150.00**

Date of Proposed Relocation:
Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Ownership:

How is the facility registered with the Secretary of State?

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ N/A

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

Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:
Name:	Title:

Name:	Title:

(Use supplemental information page if necessary)

IV. Has the pharmacy or any owners individually been subject to discipline in any jurisdiction? If so, please provide the state, case number and summary of discipline assessed.

☐ YES*	☐ NO

***If yes:** please attach statement

V. Pharmacist in Charge:

Name:	KY License No.:

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

VI. Schedule of Hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

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

Supplemental Information Page:

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 Pharmacist in Charge: **Date:**

I hereby certify that the above Application for Pharmacy Permit was signed, subscribed and sworn to before me this _____day of _____, 20_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Original Signature of Owner: **Date:**

I hereby certify that the above Application for Pharmacy Permit was signed, subscribed and sworn to before me this _____day of _____, 20_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.