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 Limited Pharmacy Permit - Medical Gas

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 ____________________

Email Address ____

Mailing Address of Facility

____
(Street and Number)

City ______________________________State __________Zip ________

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

☐ New Facility $125.00

Proposed date of Opening ____________________

(Filed with Board 30 days in advance of Opening) or Current Permit No. ____________ Expiration Date __________

(In State where presently located)

☐ 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 . . . . NO CHARGE

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. 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.

4. Schedule of Hours:

Monday . . ________ AM to ________ PM

Tuesday . . ________ AM to ________ PM

Wednesday .________ AM to ________ PM

Thursday . . . ________ AM to ________ PM

Friday . . ________ AM to ________ PM

Saturday . ________ AM to ________ PM

Sunday . . ________ AM to ________ PM

The Pharmacist in charge 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)

____ (Date)

____ (Original Signature of Pharmacist in Charge)

____ (Date)