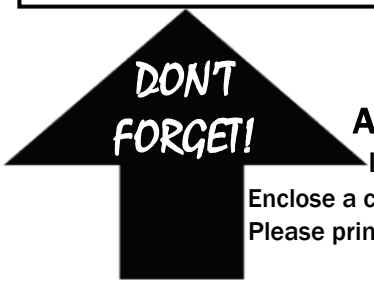
Kentucky Permit Number
P0_____



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 FOR RESIDENT PHARMACY RENEWAL

INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED.

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.

Pharmacy Name _____

Address _____

_____

Telephone Number _____ Fax Number _____

Date of last controlled substance inventory _____

DEA Registration Number _____ Expiration Date _____

Ownership:

❒ Sole Proprietor ❒ Partnership ❒ Corporation ❒ LLC ❒ Other

Name and title for each owner/officer, including office and professional designation: (Use a separate piece of paper if necessary)

_____

_____

Schedule of Hours:

*P.I.C. must notify the Board within fourteen (14) days of any changes in scheduled hours.

Monday	_____ A.M. to _____ P.M.	□ 24 Hours
Tuesday	_____ A.M. to _____ P.M.	□ 24 Hours
Wednesday	_____ A.M. to _____ P.M.	□ 24 Hours
Thursday	_____ A.M. to _____ P.M.	□ 24 Hours
Friday	_____ A.M. to _____ P.M.	□ 24 Hours
Saturday	_____ A.M. to _____ P.M.	□ 24 Hours
Sunday	_____ A.M. to _____ P.M.	□ 24 Hours

Please indicate if closed for lunch. _____

Type of Pharmacy (Indicate by circling all that apply):

Retail Independent	Retail Chain	Hospital	Charitable	Infusion
Hospital-Ambulatory	Nursing Home	Nuclear	*Internet	Mail Order

* This must be circled if the pharmacy dispenses any prescriptions to citizens of the Commonwealth of Kentucky, in whole or in part, via the Internet [agent, internet broker or shipper]. If Internet is circled, VIPPS accreditation will be verified with the NABP.

==========EMPLOYEE INFORMATION==========

Pharmacist-In-Charge(PIC): Name_____ KY License Number_____

Note: 201 KAR 2:205 requires the pharmacist-in-charge to notify the Board within fourteen [14] calendar days of all pharmacist changes.

Employees: Please provide a complete list of all employees licensed/registered with the Board. Use a separate sheet of paper if necessary.

NAME	License/Registration Number (Pharmacist, Pharmacist Intern or Pharmacy Technician)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name, title and address of each non-pharmacist with keys to the pharmacy:

_____ _____

***Please submit the name, address and affiliation of all individuals, other than those previously identified in this application, responsible for pharmacy operations, management or staffing (eg. Pharmacy Services Management companies or consultants) on a separate sheet of paper.**

1. **Does pharmacy ship medications outside of Kentucky?** _____YES _____NO
2. **Do you perform sterile compounding?** _____YES _____NO
3. **Do you perform nonsterile compounding?** _____YES _____NO
4. **Are you permitted in other states?** _____YES, please list below _____NO

   _____

5. **Have you had a Pharmacy license/permit surrendered to or fined, suspended, probated, or revoked by any Board of Pharmacy which you have not previously reported to this Board?**
   _____Yes, attach an explanation _____NO
6. **For institutional pharmacies, are there decentralized pharmacy services (i.e. oncology satellite, OR satellite, etc.) where drugs are prepared, stored, and/or compounded in the facility?**
   _____Yes, how many? _____NO

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 and 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.

_____ _____

Signature of Owner Date