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 Permit To Operate A Pharmacy In Kentucky

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 Pharmacy ______________________________

Physical Address of Pharmacy ______________________________
(Street and Number)

City ______________________________ County ______________ Zip __________

Phone Number ______________________ Fax Number ______________________

Email Address ______________________________

Mailing Address of Pharmacy ______________________________
(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)

☐ 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 ☐ Other

Name and title for each owner/officer, including professional designation *(e.g. Pres. John Jones, M.D.)*

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3. Pharmacist-In-Charge (P.I.C.) and Licensed Pharmacist(s):

Name	KY License No.	P.O.A.	Key
P.I.C.________________	__________	____	____
________________	__________	____	____
________________	__________	____	____
________________	__________	____	____
________________	__________	____	____
________________	__________	____	____

(Please indicate by checking the space provided those who have "Power of Attorney" (P.O.A) to order Controlled Substances and/or have been issued keys to the pharmacy.)

Kentucky Pharmacy Regulation 201 KAR 2:205 requires pharmacists-in-charge to notify the Board of all pharmacist personnel changes and changes in pharmacy operating hours.

4. Name and title of each non-pharmacist with keys to the pharmacy:

____

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5. Schedule of Hours:

Monday . . . . ________ A.M. to ________ P.M.

Tuesday . . . ________ A.M. to ________ P.M.

Wednesday ________ A.M. to ________ P.M.

Thursday . . . ________ A.M. to ________ P.M.

Friday . . . ________ A.M. to ________ P.M.

Saturday . . ________ A.M. to ________ P.M.

Sunday . . . ________ A.M. to ________ P.M.

Please indicate if closed for lunch. ______________

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

6. Name, address and affiliation of all individuals, other than those previously identified in this application, responsible for pharmacy management or staffing (e.g., Pharmacy Services Management Companies or Consultants):

____

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7. Type of Pharmacy (Indicate all that apply):

Retail Independent	Retail Chain	Hospital	Nursing Home	Nuclear
Internet	Mail Order	Infusion	Out-of-State	Oxygen

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 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 Pharmacist-In-Charge) *(Signature of Owner)*

________________________ ________________________

(Date) *(Date)*