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 Non-Resident Special Limited Pharmacy Permit ⇨ Charitable Pharmacy

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:

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Email Address:

Phone Number:

Fax Number:

Website Address:

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

☐ **New Facility** → **$150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

OR Current Permit No. : Exp. Date:

(In State where presently located)

☐ **Change of Ownership** → **$0**

Proposed date of Acquisition:

Name of Previous Owner(s):

(Confirmation statement of previous must be attached)

☐ **Change of Address/Location** → **$0**

Date of Proposed Relocation:
Previous Address:

☐ **Name Change** → **$0**

Previous Name:

III. Ownership:

How is the pharmacy registered with the Kentucky Secretary of State?

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

★★Please provide the following for each owner/officer/member, including professional designation (e.g. Pres. John Jones, PharmD):

Name:	Title:

Address (Home):			
CITY:	STATE:	COUNTY:	ZIP:

Address (Business):			
CITY:	STATE:	COUNTY:	ZIP:

Phone Number(Home):
Phone Number(Business):
Date of Birth:
Social Security Number:

Name:	Title:

Address (Home):			
CITY:	STATE:	COUNTY:	ZIP:

Address (Business):			
CITY:	STATE:	COUNTY:	ZIP:

Phone Number(Home):
Phone Number(Business):

Date of Birth:

Social Security Number:

Name:	Title:

Address (Home):			
CITY:	STATE:	COUNTY:	ZIP:

Address (Business):			
CITY:	STATE:	COUNTY:	ZIP:

Phone Number(Home):

Phone Number(Business):

Date of Birth:

Social Security Number:

Name:	Title:

Address (Home):

CITY:	STATE:	COUNTY:	ZIP:

Address (Business):

CITY:	STATE:	COUNTY:	ZIP:

Phone Number(Home):

Phone Number(Business):

Date of Birth:

Social Security Number:

Name:	Title:

Address (Home):

CITY:	STATE:	COUNTY:	ZIP:

Address (Business):

CITY:	STATE:	COUNTY:	ZIP:

Phone Number(Home):

Phone Number(Business):
Date of Birth:
Social Security Number:

(Use supplemental information page if necessary)

IV. 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.

V. Name and license/registration number of pharmacy employees:

Name:	License No. :
Name:	License No. :
Name:	License No. :
Name:	License No. :
Name:	License No. :
Name:	License No. :

(Use supplemental information page if necessary)

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

Name:	Title:

Name:	Title:

Name:	Title:

Name:	Title:

Name:	Title:

(Use supplemental information page if necessary)

VII. Schedule of Hours:

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

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

★Please indicate if closed for lunch:

_______________ until _______________

VIII. Discipline:

TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY TEAM KENTUCKY

Has any owner , member or officer been subject to discipline by any other agency related to the ownership or employment in a pharmacy?

☐ **YES***	☐ **NO**

***If yes:** Please explain below

:

IX. Does the pharmacy ship any prescriptions to the citizens of the Commonwealth of Kentucky under any name or return address other than the information of the pharmacy seeking or renewing a permit provided with this application?

☐ **YES***	☐ **NO**

***If yes:** Please provide a list of the additional pharmacy name(s) or return addresses that the pharmacy ships prescriptions to citizens of the Commonwealth of Kentucky and why.

____

____

____

____

____

____

(Use supplemental information page if necessary)

X. List the methods of deliver services (e.g. USPS, UPS, FedEx, etc) utilized to deliver prescriptions to citizens of the Commonwealth of Kentucky and the percentage of time each service is utilized in Kentucky.

Delivery Service Utilized:	Percentage of Time:

(Use supplemental information page if necessary)

XI. Are you permitted in other states?

☐ YES*	☐ NO

If yes: please list below

:

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Supplemental Information Page:

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REQUIRED DOCUMENTATION MUST BE ENCLOSED:

- ☐ Completed application
- ☐ Copy of Resident Pharmacy Permit
- ☐ Copy of Last Inspection Report
- ☐ Copy of DEA Registration
- ☐ Completed Attached License Verification Form or Primary Source Verification Form
- ☐ Sample Pharmacy Labels for Controlled and Non-Controlled Substances shipped into Kentucky
- ☐ Copy of the End-of-Day Report for the Seven (7) Business Days preceding the application date
- ☐ Copy of notarized *Memorandum of Understanding and Agreement*

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 DATE.

Signature of Pharmacist-in-Charge: ____________________ **Date:** ________

I hereby certify that the above Application for Non-Resident Special Limited Pharmacy Permit was signed, subscribed and sworn to before me this ________day of __________, 20_____.

By: ______________________________

Signature: ______________________________

My Commission Expires ____________________ State of _________________.

Signature of Owner: ____________________ **Date:** ________

I hereby certify that the above Application for Non-Resident Special Limited Pharmacy Permit was signed, subscribed and sworn to before me this _________day of ___________, 20______.

By: ______________________________

Signature: ______________________________

My Commission Expires ____________________ State of _________________.

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