Boards and Commissions

Kentucky Board of Pharmacy

(Amendment)

201 KAR 2:050. Licenses and permits; fees.

RELATES TO: KRS 218A.205(3)(g), 315.035(1), (2), (4), 315.0351(1), 315.036(1), 315.050(5), 315.060, 315.110, 315.120, 315.191, 315.402

STATUTORY AUTHORITY: KRS 218A.205(3)(g), 315.035(1), (2), (4), 315.036(1), 315.050(5), 315.060, 315.110(1), 315.120(4), 315.191(1)(i), 315.402(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 315.191(1)(i) authorizes the board to assess reasonable fees for services rendered to perform its duties and responsibilities. This administrative regulation establishes reasonable fees for the board to perform all the functions for which it is responsible.

Section 1. The following fees shall be paid in connection with pharmacist examinations and licenses, pharmacy permits, intern certificates, and the issuance and renewal of licenses and permits:

(1) Application for initial pharmacist license – $150;

(2) Application and initial license for a pharmacist license by license transfer - $250;

(3) Annual renewal of a pharmacist license – ninety-five (95) dollars;

(4) Delinquent renewal penalty for a pharmacist license – ninety-five (95) dollars;

(5) Annual renewal of an inactive pharmacist license–ten (10) dollars;

(6) Pharmacy intern certificate valid six (6) years –twenty-five (25) dollars;

(7) Duplicate of original pharmacist license wall certificate - seventy-five (75) dollars;

(8) Application for a permit to operate a pharmacy - $150 [~~$125~~];

(9) Renewal of a permit to operate a pharmacy - $150 [~~$125~~];

(10) Delinquent renewal penalty for a permit to operate a pharmacy – $150 [~~$100~~] dollars;

(11) Change of location or change of ownership of a pharmacy or manufacturer permit - $150 [~~seventy-five (75) dollars~~];

(12) Application for a permit to operate as a manufacturer - $150 [~~$125~~];

(13) Renewal of a permit to operate as a manufacturer - $150 [~~$125~~];

(14) Delinquent renewal penalty for a permit to operate as a manufacturer - $150 [~~$125~~];

(15) Change of location or change of ownership of a wholesale distributor license - $150 [~~seventy-five (75) dollars~~];

(16) Application for a license to operate as a wholesale distributor -$150 [~~$125~~];

(17) Renewal of a license to operate as a wholesale distributor -$150 [~~$125~~];

(18) Delinquent renewal penalty for a license to operate as a wholesale distributor -$150 [~~$125~~]; and

(19) Query to the National Practitioner Data Bank of the United States Department of Health and Human Services – twenty-five (25) dollars;~~.~~

Section 2. Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "Application for Non-Resident Pharmacy Permit, Form 3, 6/2023

(b) Application for Non-Resident Pharmacy Permit Renewal, Form 4, 6/2023

(c) Application for Permit to Operate a Pharmacy in Kentucky, Form 1, 6/2023

(d) Application for Resident Pharmacy Permit Renewal, Form 2, 6/2023

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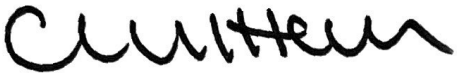
law, at the Kentucky Board of Pharmacy, State Office Building Annex, Suite 300, 125 Holmes Street, Frankfort, Kentucky, 40601, Monday through Friday, 8 a.m. to 4:30 p.m. This material is also available on the board's website at https://pharmacy.ky.gov/Businesses/Pages/Pharmacy.aspx.



June 7, 2023

Christopher Harlow, Pharm.D.
Executive Director
Board of Pharmacy

PUBLIC HEARING AND PUBLIC COMMENT PERIOD:

A public hearing on this administrative regulation shall be held on August 30, 2023, at 10:00 a.m. Eastern Time via zoom teleconference. Individuals interested in being heard at this hearing shall notify this agency in writing by five workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted through August 31, 2023. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person.

Contact person: Christopher Harlow, Executive Director, Kentucky Board of Pharmacy, 125 Holmes Street, Suite 300, State Office Building Annex, Frankfort, Kentucky 40601, phone (502) 564-7910, fax (502) 696-3806, email Christopher.harlow@ky.gov.
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REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

201 KAR 2:050 Licenses and Permits; fees.
Contact person: Christopher Harlow
Contact Phone No.: 502-564-7910
Contact email: Christopher.harlow@ky.gov

1. Provide a brief summary of:
a. What this administrative regulation does: This administrative regulation establishes the fees associated with Board of Pharmacy licensure.

b. The necessity of this administrative regulation: KRS 315.191(1)(i) authorizes the Board of Pharmacy to assess reasonable fees for services rendered to perform its duties and responsibilities. This administrative regulation establishes reasonable fees for the board to perform all the functions for which it is responsible.

c. How this administrative regulation conforms to the content of the authorizing statues: This administrative regulation establishes reasonable fees for the board to perform all the functions for which it is reasonable.

d. How this administrative regulation currently assists or will assist in the effective administration of the statutes: This regulation allows for the funding to support Board administration.

2. If this is an amendment to an existing administrative regulation, provide a brief summary of:
a. How the amendment will change this existing administrative regulation: The amendment increases fees for facilities permitted by the Board.

b. The necessity of the amendment to this administrative regulation: This administrative regulation is necessary to ensure the Board is appropriately funded to cover personnel costs and comply with the administrative functions required for pharmacies, wholesale distributors, and manufacturers.

c. How the amendment conforms to the content of the authorizing statutes: KRS 315.191(1)(i) authorizes the Board of Pharmacy to assess reasonable fees for services rendered to perform its duties and responsibilities.

d. How the amendment will assist in the effective administration of the statutes: The amendment will further promote, preserve, and protect public health through effective regulation of permitted entities.

3. List the type and number of individuals, businesses, organizations, or state and local governments affected by this administrative regulation: The board anticipates pharmacists will be affected minimally by this regulation amendment. Pharmacies, manufacturers and wholesale distributors will have increased fees of twenty-five dollars (25) for a new or a renewal license or permit. The application for change in location or change in ownership will have the same fee as the new and renewal applications because they require completion of a new application.

4. Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
a. List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: During renewal, the identified entities will have an increased permitting fee to pay.
b. In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): Cost of compliance for pharmacies, wholesale distributors, and manufacturers will be $150.
c. As a result of compliance, what benefits will accrue to the entities identified in question (3): These entities will have the benefit of ensured compliance with federal law due to the state adoption of the federal licensing standards.

5. Provide an estimate of how much it will cost to implement this administrative Regulation:
a. Initially: No costs will be incurred.
b. On a continuing basis: No costs will be incurred.
Other explanation: n/a

6. What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Board revenues from fees provide the funding to enforce the regulation.

7. Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Yes, this regulation assesses an increase in fees. The increase in fees are necessary to properly fund the Board for the administrative activities related to licensing and inspection to ensure the Board is achieving its mission of public and patient safety.

8. State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: Yes, fees for pharmacies, manufacturers, and wholesale distributors.

9. TIERING: Is tiering applied? (Explain why tiering was or was not used) Tiering is not

applied because the regulation is applicable to all pharmacies, wholesale distributors, and manufacturers.

FISCAL NOTE

Regulation No. 201 KAR 2:050 Licenses and Permits; fees.
Contact Person: Christopher Harlow
Contact Phone No.: 502-564-7910
Contact email: Christopher.harlow@ky.gov

1. What units, parts, or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Kentucky Board of Pharmacy will be the only entity impacted by this administrative regulation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 315.191(1)(i); 315.035(4); 315.036(1); 315.110(1).

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The proposed amendment will increase revenue by $91,925.
(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The proposed amendment will increase revenue by $91,925.
(c) How much will it cost to administer this program for the first year? The Board of Pharmacy does not anticipate any additional cost to administer this regulation for the first year.
(d) How much will it cost to administer this program for subsequent years? The Board of Pharmacy does not anticipate any additional cost to administer this regulation for the first year.
Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation. N/A

Revenues (+/-): Amendment will provide an annual $91,925 in revenue.

Expenditures (+/-): 0

Other Explanation: n/a

(4) Estimate the effect of this administrative regulation on the expenditures and cost savings of regulated entities for the first full year the administrative regulation is to be in effect.

(a) How much cost savings will this administrative regulation generate for the regulated entities for the first year? None.

(b) How much cost savings will this administrative regulation generate for the regulated entities for subsequent years? None.

(c) How much will it cost the regulated entities for the first year? $150 per permit.

(d) How much will it cost the regulated entities for subsequent years? $150 annually.
Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Cost Savings (+/-): 0
Expenditures (+/-): -$150
Other Explanation: n/a

(5) Explain whether this administrative regulation will have a major economic impact, as defined below. "Major economic impact" means an overall negative or adverse economic impact from an administrative regulation of five hundred thousand dollars ($500,000) or more on state or local government or regulated entities, in aggregate, as determined by the promulgating administrative bodies. [KRS 13A.010(13)] This regulation does not have major economic impact.

Summary of Material Incorporated by Reference

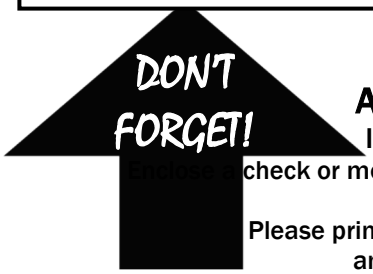
The “Application for “Non-Resident Pharmacy Permit”, June 2023 form is the 19-page form to be utilized by applicants for an initial non-resident pharmacy permit.

The “Application for “Non-Resident Pharmacy Permit –Renewal”, June 2023 is the 16-page form to be utilized by applicants for annual non-resident pharmacy permit renewal.

The “Application to Operate a Pharmacy in Kentucky”, June 2023 form is the 11-page form to be utilized by applicants for an initial resident pharmacy permit.

The “Application for “Resident Pharmacy Permit –Renewal”, June 2023 form is the 12-page form to be utilized by applicants for annual resident pharmacy permit renewal.

Kentucky Permit Number
PO



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 $150.00~~125.00~~, made payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal.

Please print legibly and complete this application; including the required original signature and return no later than June 30th. All renewals received after June 30th will be assessed a delinquent fee of $150.00 ~~100.00~~ pursuant to 201 KAR 2:050, Section 1(10)~~(11)~~.

1. Pharmacy Name _____

Address _____

_____

Telephone Number_____Fax Number_____Email Address_____

Website Address: _____

Date of last controlled substance inventory _____

DEA Registration Number _____ Expiration Date _____

~~**Ownership:**~~

2. How are you registered with the Kentucky Secretary of State?

❒ 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. _____

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

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

Compounding

* 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, digital pharmacy accreditation ~~VIPPS accreditation~~ will be verified with the NABP.

4. 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.

5. Does pharmacy ship medications outside of Kentucky? _____YES _____NO

6. Do you perform sterile compounding? _____YES _____NO

7. Do you perform nonsterile compounding? _____YES _____NO

8. Are you permitted in other states? _____YES, please list below _____NO

_____

9. Have you had a Pharmacy license/permit disciplined by any other agency or has your PIC been disciplined by any other agency ~~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

10. 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

11. Does this pharmacy stock any emergency medication kits? ___yes ____no

12. Does this pharmacy stock any long-term care facility in Kentucky? ___yes ____no

13. Does this pharmacy utilize any automation for prescription dispensing? ___yes ____no If so, please attach an explanation

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

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

By: _____Signature_____

My Commission Expires_____State of _____

Signature of Pharmacist-in-Charge _____
Date

I hereby certify that the above Renewal **Application for Resident Pharmacy Permit** was signed, subscribed and sworn to before me this_____day of _____, 20____

By: _____Signature_____

My Commission Expires_____State of_____

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 Resident Pharmacy Renewal

Enclose a check or money order for $150.00, made payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal
Please print legibly and complete this application; including the required original signature and return no later than June 30th. All renewals received after June 30th will be assessed a delinquent fee of $150.00 pursuant to 201 KAR 2:050, Section 1(10).

INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED

I. Pharmacy Information:

Name of Pharmacy			
Kentucky Permit Number:			
Address:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			

Phone Number:
Fax Number:
Website Address:
Date of last controlled substance inventory:

DEA Registration No.:	Exp. Date:

II. Ownership:

How are you registered with the Kentucky Secretary of State?

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ Corporation
- ☐ LLC
- ☐ Other

★★ Name and title for each owner/officer/member, including office and professional designation:

1.

Name:	Title:

2.

Name:	Title:

3.

Name:	Title:

4.

Name:	Title:

5.

Name:	Title:

(Use supplemental information page if necessary)

III. Schedule of Hours:

(P.I.C. 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:
☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS

★Please indicate if closed for lunch:

_____ until _____

IV. Types of Pharmacy (Check all that apply):

- ☐ **Retail Independent**
- ☐ **Retail Chain**
- ☐ **Infusion**
- ☐ **Nuclear**
- ☐ **Mail Order**
- ☐ **Nursing Home**
- ☐ **Internet***
- ☐ **Hospital**
- ☐ **Hospital-Ambulatory**
- ☐ **Central Fill**
- ☐ **Compounding**
- ☐ **Veterinary**

*This must be checked 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 checked, digital pharmacy accreditation will be verified with the NABP.

V. Does pharmacy ship medications outside of Kentucky?

☐ **YES**	☐ **NO**

VI. Do you perform sterile compounding?

☐ **YES**	☐ **NO**

VII. Do you perform non-sterile compounding?

☐ **YES**	☐ **NO**

VIII. Are you permitted in other states?

☐ **YES**	☐ **NO**

If yes: Please list below

:

IX. Have you had a Pharmacy license/permit disciplined by any other agency or has your PIC been disciplined by any other agency which you have not previously reported to this Board?

☐ YES*	☐ NO

If yes: Please explain below

:

X. 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*	☐ NO

If yes: how many?

:

XI. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

XII. Does this pharmacy stock any long-term care facility in Kentucky?

☐ YES	☐ NO

XIII. Does this pharmacy utilize any automation for prescription dispensing?

☐ YES*	☐ NO

If yes: Please explain below

:

EMPLOYEE INFORMATION:

1. 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.

2. Please provide a complete list of all employees licensed/registered with the Board:

Name:	License/Registration Number (Pharmacist, Pharmacist Intern or Pharmacy Technician):
1.	

2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

(Use supplemental information page if necessary)

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

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:
Address:	
CITY: STATE: COUNTY: ZIP:	

Name:	Title:
Address:	
CITY: STATE: COUNTY: ZIP:	

Name:	Title:
Address:	
CITY: STATE: COUNTY: ZIP:	

(Use supplemental information page if necessary)

4. **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):**

Name:	Affiliation:
Address:	
CITY: STATE: COUNTY: ZIP:	

Name:	Affiliation:
Address:	
CITY: STATE: COUNTY: ZIP:	

Name:	Affiliation:
Address:	
CITY: STATE: COUNTY: ZIP:	

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary

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 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:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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' 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.

1. Name of Pharmacy _____

Physical Address of Pharmacy _____
(Street and Number)

City _____ County _____ Zip _____

Phone Number _____ Fax Number _____

Email Address _____
Website Address _____

Mailing Address of Pharmacy _____
(Street and Number)

City _____State _____Zip _____

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

☐ New Facility . . . . . $150.00~~125.00~~

Proposed date of Opening _____
(Filed with Board 30 days in advance of Opening)

☐ Change of Ownership . . . . . $150.00~~75.00~~

Date of Proposed Acquisition _____

Name of Previous Owner(s) _____

(Please include detailed explanation of the change, including type of transaction, date of transaction and structure of the transfer ~~Confirmation statement of previous owner must be attached along with an explanation of the change.~~)

☐ Change of Address/Location . . . . . $150.00~~75.00~~

Date of Proposed Relocation _____

Previous Address _____

☐ Name Change . . . . . NO CHARGE

Previous Name _____

2. **Ownership. How is the pharmacy registered with the Kentucky Secretary of State?:**

☐ Sole Proprietor ☐ Partnership ☐ LLC ~~Unincorporated Business~~ ☐ Corporation ~~Incorporated Business~~ ☐ Other

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

_____

_____ 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 attach a statement).

3. **Pharmacist-In-Charge (P.I.C.), ~~and Licensed~~ Pharmacist(s), Interns and Technicians:**

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:**

_____

_____

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):**

_____

_____

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

Retail Independent Retail Chain Hospital-Ambulatory Compounding Nursing Home Nuclear

Internet Veterinary Mail Order Infusion Central Fill ~~Out-of-State~~ ~~Oxygen~~

8. **Does pharmacy currently utilize an automated data processing system?** _____Yes* _____No

*If yes, identify the source for: hardware _____ software _____

9. Does the pharmacy plan on obtaining a Digital Pharmacy accreditation or Healthcare Merchant (veterinary) accreditation?

10. Do you plan on performing sterile compounding? _____Yes _____No

11. Do you plan on performing nonsterile compounding? _____Yes _____No

12. Does this pharmacy stock any emergency medication kits? ___yes ____no

13. Does this pharmacy stock any long-term care facility in Kentucky? ___yes ____no

14. Does this pharmacy utilize any automation for prescription dispensing? ___yes ____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 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)*~~

_____ _____

Signature of Pharmacist-in-Charge Date

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

Signature_____

My Commission Expires_____State of _____

_____ _____

Signature of Owner Date

I hereby certify that the above **Application for Resident Pharmacy Permit** was signed, subscribed and sworn to before me this_____day of _____, 20____

Signature_____

My Commission Expires_____State of_____

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 Permit To Operate A Pharmacy In Kentucky

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' 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. Pharmacy Information:

Name of Pharmacy:
Physical Address of Pharmacy:
CITY: STATE: COUNTY: ZIP:
Email:
Phone number:

Fax number:
Website Address:
Mailing Address of Pharmacy:
CITY: STATE: COUNTY: ZIP:

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)

☐ **Change of Ownership** → **$150.00**

Proposed date of acquisition:
Name of previous owner(s):

(Please include detailed explanation of the change, including type of transaction, date of transaction and structure of the transfer)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Ownership:

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

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ Other

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

1.

Name:	Title:

2.

Name:	Title:

3.

Name:	Title:

4.

Name:	Title:

5.

Name:	Title:

(Use supplemental information page if necessary)

IV. 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

:

V. Pharmacist-In-Charge (P.I.C.), Pharmacist(s), Interns and Technicians :

Name	KY License No.:	P.O.A.	Key
P.I.C. :		☐	☐
		☐	☐
		☐	☐

		☐	☐
		☐	☐

(Use supplemental information page if necessary)

(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.

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

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

(Use supplemental information page if necessary)

VII. Schedule of Hours:

(P.I.C. 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. 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) :

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary)

IX. Type of Pharmacy (Check all that apply) :

- ☐ **Retail Independent**
- ☐ **Retail Chain**
- ☐ **Infusion**
- ☐ **Nuclear**
- ☐ **Mail Order**
- ☐ **Nursing Home**
- ☐ **Internet**
- ☐ **Hospital- Ambulatory**
- ☐ **Central Fill**
- ☐ **Compounding**
- ☐ **Veterinary**

X.Does pharmacy currently utilize an automated data processing system?

☐ YES*	☐ NO

*If yes: identify the source for:

Hardware: _____

Software: _____

XI.Does the pharmacy plan on obtaining a Digital Pharmacy accreditation or Healthcare Merchant (veterinary) accreditation?

☐ YES	☐ NO

XII. Do you plan on performing sterile compounding?

☐ YES	☐ NO

XIII. Do you plan on performing non-sterile compounding?

☐ YES	☐ NO

XIV. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

XV. Does this pharmacy stock any long-term care facility in Kentucky?

☐ YES	☐ NO

XVI. Does this pharmacy utilize any automation for prescription dispensing?

☐ YES	☐ NO

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 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: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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 Non-Resident Pharmacy Permit

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 completed application to the above address. All applicable entries must be completed. Please use the checklist of required documentation at the end of this application. 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 _____State _____Zip _____

Phone Number _____Toll Free Number_____Fax Number _____

Website Address_____Email Address _____

Mailing Address of Pharmacy _____
(Street and Number)

City _____ State _____ Zip _____

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

☐ New Pharmacy . . . . . $150.00 ~~$125.00~~
Proposed date of Opening _____
(Filed with Board 30 days in advance of Opening)

☐ Change of Ownership . . . . . $150.00 ~~75.00~~
Date of Proposed Acquisition _____
Name of Previous Owner(s) _____
(REQUIRED DOCUMENT: Confirmation statement of previous owner OR Must submit legal documentation detailing the specific ownership changes of ownership change)

☐ Change of Address/Location . . . . . $150.00~~75.00~~
Date of Proposed Relocation _____
Previous Address _____

☐ Name Change . . . . . NO CHARGE
Previous Name _____

2. Ownership:

☐ Sole Proprietor ☐ Partnership ☐LLC ~~Unincorporated Business~~ ☐ Corporation ~~Incorporated Business~~

☐ Other

On a separate sheet of paper, please provide the following information for each owner/officer/member, including professional designation (e.g. Pres. John Jones, M.D.):

- Name and Title
- Address (Business and Home)
- Phone Number (Business and Home)
- Social Security Number
- Date of Birth

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

Name Kentucky License No.

P.I.C._____ _____

List the names and ~~Kentucky~~ home state license numbers of any staff pharmacist~~s~~ performing any function on a prescription for a KY patient ~~licensed with~~ Kentucky:

Name License No.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

(Use a separate piece of paper if necessary)

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

~~Senate Bill 88 amends~~ KRS 315.0351 to require out-of-state pharmacies who are providing prescription medications to citizens of the Commonwealth to have a pharmacist-in-charge who holds a Kentucky pharmacist license. This Kentucky licensed pharmacist may be any employee pharmacist of the pharmacy.

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

_____

_____

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.

**P.I.C. must notify the Board within fourteen (14) days of any changes in scheduled hours. KRS 315.0351 requires the pharmacy be open 6 days a week or provide documentation for on call hours with a toll free telephone service directly to the pharmacist available to the patient.

6. **Does pharmacy currently utilize an automated data processing system?** _____Yes* _____No

*If yes, identify the source for: hardware _____ software _____

7. **TYPES OF PHARMACY (INDICATE BY CIRCLING ALL THAT APPLY):**

Retail Independent	Retail Chain	Hospital	Nursing Home	Nuclear Central Fill
* Internet	Mail Order	Infusion	~~Out-of-State~~	Oxygen Compounding

* 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. Section 8 must be completed.

8. Does the pharmacy have a Digital Pharmacy accreditation or Healthcare Merchant (veterinary) accreditation ~~Is the pharmacy VIPPS accredited~~? _____Yes _____No

9. Does the pharmacy dispense any prescriptions to citizens of the Commonwealth of Kentucky that have been referred to the pharmacy, in whole or in part, by an outside agent (e.g. internet broker)? _____Yes* _____No
*If yes: Approximately how many anticipated or actual prescriptions dispensed to citizens of the Commonwealth of Kentucky per calendar month are referred to the pharmacy by agent(s). _____

List the name, address, phone number, and email address of all agents:

NAME ADDRESS PHONE NUMBER EMAIL ADDRESS

_____

_____

_____

(Use a separate piece of paper if necessary)

10. Does the pharmacy employ, contract with, or compensate directly or indirectly physicians to authorize prescriptions for citizens of the Commonwealth of Kentucky? _____Yes* _____No

*If yes: On a separate sheet of paper, please provide the following information for all physicians:

- Name
- Business Address
- Business Phone
- Email address
- DEA number
- State(s) of licensure
- Date of Birth
- Social Security number

11. 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 a separate piece of paper if necessary)

12. List the methods of delivery services (e.g. USPS, UPS, ~~DHL,~~ 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 Utilized
_____	_____
_____	_____
_____	_____
_____	_____

13. Are you permitted in other states? _____Yes, please list below _____No

_____

14. Has the pharmacy or pharmacist in charge been subject to discipline in any jurisdiction? If so, please provide the state, case number and summary of discipline assessed. _____Yes, please attach statement _____No

15. Has the pharmacy shipped drugs into Kentucky prior to obtaining a permit? _____yes _____no

16. Do you perform sterile compounding? _____Yes _____No

17. Do you perform nonsterile compounding? _____Yes _____No

18. Does this pharmacy stock any emergency medication kits? ____yes _____no

19. Does this pharmacy stock any long term care facility in Kentucky? ____yes _____no

20. Does this pharmacy utilize any automation for prescription dispensing? ____yes _____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 Pharmacist-in-Charge Date

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

Signature_____

My Commission Expires_____State of _____

_____ _____
Signature of Owner Date

I hereby certify that the above **Application for Non-Resident Pharmacy Permit** was signed, subscribed and sworn to before me this_____day of _____, 20____

Signature_____

My Commission Expires_____State of_____

REQUIRED DOCUMENTATION MUST BE ENCLOSED:

~~[FOR INITIAL APPLICATIONS ONLY]~~

- 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 ~~of any Pharmacy Label used to ship~~ 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*
- *Ownership Information as described in section 2.*

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 Pharmacy Permit

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 completed application to the above address. All applicable entries must be completed. Please use the checklist of required documentation at the end of this application. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Pharmacy Information:

Name of Pharmacy			
Physical Address of Pharmacy:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing Address of Pharmacy:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			

Phone Number:
Fax Number:
Toll Free Number:
Website Address:

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

☐ **New Pharmacy → $150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

☐ **Change of Ownership → $150.00**

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

(Must submit documentation detailing the specific ownership changes)

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

Date of Proposed Relocation:

Previous Address:			
CITY:	STATE:	COUNTY:	ZIP:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Ownership:

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

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ Other

★★please provide the following information for each owner/officer, including professional designation (e.g. Pres. John Jones, M.D.):

1.

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

Address(Home):			
CITY:	STATE:	COUNTY:	ZIP:
Phone number(Business):			
Phone number(Home):			
Social Security Number:	Date of Birth:		

2.

Name:	Title:
Address(Business):	
CITY: STATE: COUNTY: ZIP:	
Address(Home):	
CITY: STATE: COUNTY: ZIP:	
Phone number(Business):	
Phone number(Home):	
Social Security Number:	Date of Birth:

3.

Name:	Title:

Address(Business):			
CITY:	STATE:	COUNTY:	ZIP:
Address(Home):			
CITY:	STATE:	COUNTY:	ZIP:
Phone number(Business):			
Phone number(Home):			
Social Security Number:		Date of Birth:	

4.

Name:			Title:
Address(Business):			
CITY:	STATE:	COUNTY:	ZIP:
Address(Home):			
CITY:	STATE:	COUNTY:	ZIP:
Phone number(Business):			
Phone number(Home):			
Social Security Number:		Date of Birth:	

5.

Name:	Title:
Address(Business):	
CITY: STATE: COUNTY: ZIP:	
Address(Home):	
CITY: STATE: COUNTY: ZIP:	
Phone number(Business):	
Phone number(Home):	
Social Security Number:	Date of Birth:

(Use supplemental information page if necessary)

IV. Pharmacist-In-Charge (P.I.C.) :

P.I.C. :	KY License No.:

★★List the names and home state license numbers of any staff performing any function on a prescription for a KY patient:

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

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

(Use supplemental information page if necessary)

Kentucky Pharmacy Regulation 201 KAR 2:205 requires pharmacists-in-charge to notify the Board within fourteen (14) calendar days of all pharmacist-in-charge and staff pharmacist changes.
KRS 315.0351 to require out-of-state pharmacies who are providing prescription medications to citizens of the Commonwealth to have a pharmacist-in-charge who holds a Kentucky pharmacist license. This Kentucky licensed pharmacist may be any employee pharmacist of the pharmacy.

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

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

(Use supplemental information page if necessary)

VI. Schedule of Hours:

(P.I.C. 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:

KRS 315.0351 requires the pharmacy be open 6 days a week or provide documentation for on-call hours with a toll free telephone service directly to the pharmacist available to the patient.

VII. Does pharmacy currently utilize an automated data processing system?

☐ **YES***	☐ **NO**

If yes: identify the source for:

Hardware: _____

Software: _____

VIII. Types of Pharmacy (Check all that apply):

☐ **Retail Independent**	☐ **Retail Chain**	☐ **Infusion**
☐ **Nuclear**	☐ **Mail Order**	☐ **Nursing Home**
☐ **Internet***	☐ **Hospital**	☐ **Compounding**
☐ **Central Fill**	☐ **Oxygen**	☐ **Veterinary**

*This must be checked 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 checked, Section 9 must be completed.

IX. Does the pharmacy have a Digital Pharmacy accreditation or Healthcare Merchant (veterinary) accreditation?

☐ YES	☐ NO

X. Does the pharmacy dispense any prescriptions to citizens of the Commonwealth of Kentucky that have been referred to the pharmacy, in whole or in part, by an outside agent (e.g. internet broker)?

☐ YES*	☐ NO

If yes: Approximately how many anticipated or actual prescriptions dispensed to citizens of the Commonwealth of Kentucky per calendar month are referred to the pharmacy by agent(s).

:

★★List the name, address, phone number, and email address of all agents:

1.Name:
Address:
CITY: STATE: COUNTY: ZIP:
Email Address:
Phone Number:

2.Name:

Address:

CITY: STATE: COUNTY: ZIP:

Email Address:

Phone Number:

3.Name:

Address:

CITY: STATE: COUNTY: ZIP:

Email Address:

Phone Number:

4.Name:

Address:

CITY: STATE: COUNTY: ZIP:

Email Address:

Phone Number:

5.Name:
Address:
CITY: STATE: COUNTY: ZIP:
Email Address:
Phone Number:

(Use supplemental information page if necessary)

XI. Does the pharmacy employ, contract with, or compensate directly or indirectly physicians to authorize prescriptions for citizens of the Commonwealth of Kentucky?

☐ **YES***	☐ **NO**

If yes: please provide the following information for all physicians:

1.Name:
Business Address:
CITY: STATE: COUNTY: ZIP:
Business Phone:

Email Address:	
DEA Number:	State(s) of licensure:
Social Security Number:	Date of Birth:

2.Name:			
Business Address:			
CITY:	STATE:	COUNTY:	ZIP:
Business Phone:			
Email Address:			
DEA Number:	State(s) of licensure:		
Social Security Number:	Date of Birth:		

3.Name:			
Business Address:			
CITY:	STATE:	COUNTY:	ZIP:
Business Phone:			

Email Address:	
DEA Number:	State(s) of licensure:
Social Security Number:	Date of Birth:

4.Name:			
Business Address:			
CITY:	STATE:	COUNTY:	ZIP:
Business Phone:			
Email Address:			
DEA Number:	State(s) of licensure:		
Social Security Number:	Date of Birth:		

5.Name:			
Business Address:			
CITY:	STATE:	COUNTY:	ZIP:
Business Phone:			

Email Address:	
DEA Number:	State(s) of licensure:
Social Security Number:	Date of Birth:

(Use supplemental information page if necessary)

XII. 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)

XIII. 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)

XIV. Are you permitted in other states?

☐ YES*	☐ NO

If yes: please list below

:

XV. Has the pharmacy or pharmacist in charge 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

XVI. Has the pharmacy shipped drugs into Kentucky prior to obtaining a permit?

☐ YES	☐ NO

XVII. Do you perform sterile compounding?

☐ YES	☐ NO

XVIII. Do you perform nonsterile compounding?

☐ YES	☐ NO

XIX. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

XX. Does this pharmacy stock any long term care facility in Kentucky?

☐ YES	☐ NO

XXI. Does this pharmacy utilize any automation for prescription dispensing?

☐ YES	☐ NO

XXII. Date of last controlled substance inventory:

Date:

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 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: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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*

Kentucky Permit Number
_____

KENTUCKY BOARD OF PHARMACY
State Office Building Annex, Suite 300
125 Holmes Street
Frankfort KY 40601
Phone (502) 564-7910 Fax (502) 696-3806

DON'T FORGET!

Application For Non-Resident Pharmacy Permit Renewal

Please print legibly. Make check or money order for $150 ~~125~~ made payable to 'Kentucky State Treasurer' Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal. Mail completed application including the required original signatures and mail to the above address. All applications must be received in the Board office by June 30th.

1. Name of Pharmacy _____

Physical Address of Pharmacy _____
(Street and Number)
City _____State _____Zip _____

Phone Number _____Toll Free Number_____Fax Number _____

Website Address_____Email Address _____

Date of last controlled substance inventory
_____

Mailing Address of Pharmacy _____
(Street and Number)
City _____ State _____ Zip _____

~~INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED.~~

DEA Registration No._____ Expiration Date:_____

Ownership:
How are you registered with the Kentucky Secretary of State?
❒ 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)
_____
_____
_____
_____

2. Pharmacist-In-Charge (P.I.C.):

Name Kentucky License No. City of Residence

P.I.C._____ _____ _____

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

~~Senate Bill 88 amends~~ KRS 315.0351 to require out-of-state pharmacies who are providing prescription medications to citizens of the Commonwealth to have a pharmacist-in-charge who holds a Kentucky pharmacist license. This Kentucky licensed pharmacist may be any employee pharmacist of the pharmacy.

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

_____

4. 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. Thursday . . . _____ A.M. to _____ P.M. Sunday . . . _____ A.M. to _____ P.M.

Tuesday . . . _____ A.M. to _____ P.M. Friday . . . _____ A.M. to _____ P.M.

Wednesday . _____ A.M. to _____ P.M. Saturday . ._____ A.M. to _____ P.M.

KRS 315.0351 requires the pharmacy be open 6 days a week or provide documentation for on call hours with a toll free telephone service directly to the pharmacist available to the patient.

5. List the names and resident state license numbers of any staff pharmacist performing any function on a prescription for a KY patient:

Name	License No.

(Use a separate piece of paper if necessary)

6. TYPES OF PHARMACY (INDICATE BY CIRCLING ALL THAT APPLY):

Retail Independent	Retail Chain	Hospital	Nursing Home Nuclear Veterinary
* Internet	Mail Order	Infusion	Central Fill ~~Out of State~~ ~~Oxygen~~

Compounding

*** 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, digital pharmacy accreditation ~~VIPPS accreditation~~ will be verified with the NABP and Section 7 must be completed.**

7. Does the pharmacy dispense any prescriptions to citizens of the Commonwealth of Kentucky that have been referred to the pharmacy, in whole or in part, by an outside agent (e.g. internet broker)? _____Yes* _____No
*If yes: Approximately how many anticipated or actual prescriptions dispensed to citizens of the Commonwealth of Kentucky per calendar month are referred to the pharmacy by agent(s). _____

List the name, address, phone number, and email address of all agents:

NAME	ADDRESS	PHONE NUMBER	EMAIL ADDRESS

(Use a separate piece of paper if necessary)

8. Does the pharmacy employ, contract with, or compensate directly or indirectly physicians to authorize prescriptions for citizens of the Commonwealth of Kentucky? _____Yes* _____No

*If yes: On a separate sheet of paper, please provide the following information for all physicians:

- Name
- Business Address
- Business Phone
- Email address
- DEA number
- State(s) of licensure
- Date of Birth[Month and Year only]
- Social Security number [optional]

9. 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 a separate piece of paper if necessary)

_____

_____

10. Do you perform sterile compounding? _____Yes _____No

11. Do you perform nonsterile compounding? _____Yes _____No

12. Are you permitted in other states? _____Yes, please list below _____No

_____

13. Have you had a Pharmacy license/permit disciplined by any other agency **or has your PIC been disciplined by any other agency** ~~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

14. List the names and resident state license numbers of any staff pharmacist performing any function on a prescription for a KY patient:

Name	License No.

(Use a separate piece of paper if necessary)

15. Does this pharmacy stock any emergency medication kits? ___yes ____no

16. Does this pharmacy stock any long term care facility in Kentucky? ___yes ____no

17. Does this pharmacy utilize any automation for prescription dispensing? ___yes ____no If so, please attach an explanation

~~Kentucky Pharmacy Regulation 201 KAR 2:205 requires pharmacists-in-charge to notify the Board within fourteen (14) calendar days of all pharmacist-in-charge and staff pharmacist changes.~~

PLEASE INCLUDE A COPY OF YOUR MOST RECENT PHARMACY INSPECTION WITH THIS APPLICATION.

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 Pharmacist-in-Charge Date

I hereby certify that the above Renewal **Application for Non-Resident 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 Renewal **Application for Non-Resident Pharmacy Permit** was signed, subscribed and sworn to before me this_____day of _____, 20____

By:_____Signature_____

My Commission Expires_____State of_____

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 Pharmacy Permit Renewal

Please print legibly. Make check or money order for $150, made payable to 'Kentucky State Treasurer' Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Mail completed application including the required original signatures and mail to the above address. All applications must be received in the Board office by June 30th.

I. Pharmacy Information:

Name of Pharmacy			
Kentucky Permit Number:			
Physical Address of Pharmacy:			
CITY:	STATE:	COUNTY:	ZIP:
Email:			

Phone number:			
Fax number:			
Toll Free Number:			
Website Address:			
Date of last controlled substance inventory:			
Mailing Address of Pharmacy:			
CITY:	STATE:	COUNTY:	ZIP:
DEA Registration No.:		Exp. Date:	

II. Ownership:

How are you registered with the Kentucky Secretary of State?

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ Other

★★ Name and title for each owner/officer/member, including office and professional designation:

1.

Name:	Title:

2.

Name:	Title:

3.

Name:	Title:

4.

Name:	Title:

5.

Name:	Title:

(Use supplemental information page if necessary)

III. Pharmacist-In-Charge (P.I.C.) :

P.I.C. :	KY License No.:

City of Residence:

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

KRS 315.0351 to require out-of-state pharmacies who are providing prescription medications to citizens of the Commonwealth to have a pharmacist-in-charge who holds a Kentucky pharmacist license. This Kentucky licensed pharmacist may be any employee pharmacist of the pharmacy.

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

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary)

V. Schedule of Hours:

(P.I.C. 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:

KRS 315.0351 requires the pharmacy be open 6 days a week or provide documentation for on-call hours with a toll free telephone service directly to the pharmacist available to the patient.

VI. List the names and resident state license numbers of any staff pharmacist performing any function on a prescription for a KY patient:

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

Name: License No. :

(Use supplemental information page if necessary)

VII. Types of Pharmacy (Check all that apply):

☐ **Retail Independent**	☐ **Retail Chain**	☐ **Infusion**
☐ **Nuclear**	☐ **Mail Order**	☐ **Nursing Home**
☐ **Internet***	☐ **Hospital**	☐ **Central Fill**
☐ **Compounding**	☐ **Veterinary**	

*This must be checked 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 checked, digital pharmacy accreditation will be verified with the NABP and Section 8 must be completed.

VIII. Does the pharmacy dispense any prescriptions to citizens of the Commonwealth of Kentucky that have been referred to the pharmacy, in whole or in part, by an outside agent (e.g. internet broker)?

☐ **YES***	☐ **NO**

If yes: Approximately how many anticipated or actual prescriptions dispensed to citizens of the Commonwealth of Kentucky per calendar month are referred to the pharmacy by agent(s).

: _____

★★List the name, address, phone number, and email address of all agents:

1.Name:

Address:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			
Phone Number:			

2.Name:			
Address:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			
Phone Number:			

3.Name:			
Address:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			

Phone Number:

4.Name:
Address:
CITY: STATE: COUNTY: ZIP:
Email Address:
Phone Number:

5.Name:
Address:
CITY: STATE: COUNTY: ZIP:
Email Address:
Phone Number:

(Use supplemental information page if necessary)

IX. Does the pharmacy employ, contract with, or compensate directly or indirectly physicians to authorize prescriptions for citizens of the Commonwealth of Kentucky?

☐ YES*	☐ NO

If yes: please provide the following information for all physicians:

1.Name:	
Business Address:	
CITY: STATE: COUNTY: ZIP:	
Business Phone:	
Email Address:	
DEA Number:	State(s) of licensure:
Social Security Number: (optional)	Date of Birth:

2.Name:	
Business Address:	
CITY: STATE: COUNTY: ZIP:	
Business Phone:	
Email Address:	

DEA Number:	State(s) of licensure:
Social Security Number: (optional)	Date of Birth:

3.Name:
Business Address:
CITY: STATE: COUNTY: ZIP:
Business Phone:
Email Address:

DEA Number:	State(s) of licensure:
Social Security Number: (optional)	Date of Birth:

4.Name:
Business Address:
CITY: STATE: COUNTY: ZIP:
Business Phone:

Email Address:	
DEA Number:	State(s) of licensure:
Social Security Number: (optional)	Date of Birth:

5.Name:			
Business Address:			
CITY:	STATE:	COUNTY:	ZIP:
Business Phone:			
Email Address:			

DEA Number:	State(s) of licensure:
Social Security Number: (optional)	Date of Birth:

(Use supplemental information page if necessary)

X. 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)

XI. Do you perform sterile compounding?

☐ YES	☐ NO

XII. Do you perform non-sterile compounding?

☐ YES	☐ NO

XIII. Are you permitted in other states?

☐ YES*	☐ NO

If yes: Please list below

:

XIV. Have you had a Pharmacy license/permit disciplined by any other agency or has your PIC been disciplined by any other agency which you have not previously reported to this Board?

☐ **YES***	☐ **NO**

If yes: Please explain below

:

XV. List the names and resident state license numbers of any staff pharmacist performing any function on a prescription for a KY patient:

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

(Use supplemental information page if necessary)

XVI. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

XVII. Does this pharmacy stock any long term care facility in Kentucky?

☐ YES	☐ NO

XVIII. Does this pharmacy utilize any automation for prescription dispensing?

☐ YES*	☐ NO

If yes: Please explain below

:

Supplemental Information Page:

PLEASE INCLUDE A COPY OF YOUR MOST RECENT PHARMACY INSPECTION WITH THIS APPLICATION

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 Pharmacist-In-Charge: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.