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 as a Manufacturer or Virtual Manufacturer

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 September 30th following the date of issuance.

Name of Facil	ity:		
Physical Addr	ess of Facility:		
CITY:	STATE:	COUNTY:	ZIP:
Mailing addre	ss of facility:		
CITY:	STATE:	COUNTY:	ZIP:









	Phone Number:
	Fax Number:
	Website Address:
Ι	. Check and complete one of the following and attach proper fee:
	□ <u>New Manufacturer or Virtual Manufacturer</u> → \$150.00
	Proposed date of opening:
	(Filed with Board 30 days in advance of Opening)
	□ <u>Change of Ownership</u> → \$150.00 Proposed date of Acquisition:
	Name of Previous Owner(s).
	(Confirmation statement from previous owner must be attached)
	□ <u>Change of Address/Location</u> → \$150.00
	Date of Proposed Relocation:









□ <u>Name Change</u> → NO CHARGE

	Numbers and Expirat	tion Dates:
DEA:		Exp. Date:
FDA:		Exp. Date:
Email Address:	<u>aly</u>	
Email Address:	ally.	
	.e	

If yes: please provide explanation below:









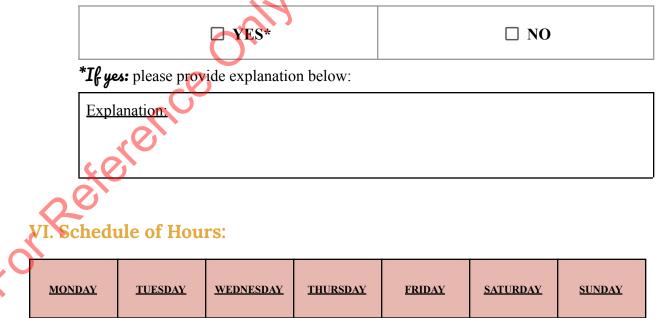


Explanation:

2. Has the applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever had a license or permit related to drugs revoked or suspended by any federal, state, or local government?

□ YES*	
*If yes: please provide explanation below:	ico
Explanation:	299.

3. Has the applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever been convicted under federal, state and/or local laws relating to drugs, including drug samples and controlled substances?













OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
				I	I	Or
/II. Iden	ntify the P	harmacist	-In-Cha	arge:	•	6
Name:				License No.:	ð	
	201 KAR 2:20)5 requires pharm	nacists-in-ch	arge to notify the Bo	oard of all person	nnel changes.
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/III. Ow	nership:			it r	•	
	-	v registere	d with 1	hekentuck	v Secretar	v of State?
	e Proprietor				,	J
	tnership					
	-	X	Υ.			
	rporation					
□ Oth						
				4 60		
\mathbf{X}	Name and	d title for	each ow	vner/officer/	/manager,	including
S.	professio	nal design	nation (e	e.g. Pres. Joh	n Jones, N	I.D.):
Name:				Tit	le:	
Name:				Tit	le:	
Name:				Tit	le:	
Name:				Tit	e.	









Name:		Title:
Name:		Title:
	(Use supplemental information	on page if necessary)
IX Has thi	s facility had an FDA or thi	rd-party inspection?
17X. 1145 UII	s facility had all PDA of this	ru party inspection:
	□ YES*	
*If yes: please	provide a copy of the inspection repo	ort
-		No.
		Continue Destat
	Supplemental Info	mation Page:
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Changes in the above information must be submitted in writing with the appropriate application fee to the Board office within thirty (30) days.

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. If the registration herein applied for is granted, I certify that this business will be conducted in full compliance with all applicable federal and state laws and that I will make available any or all records required by law to the extent authorized by law.

I hereby certify that the above Application for Manufactu	rer/Virtual Manufa	cturer Permit v
signed, subscribed and sworn to before me this	day of	, 20
10 ¹		
By:		
Signature:		
My Commission Expires	State of	
ature of Owner:	11/2	Date:
ature of Owner: I hereby certify that the above Application for Manufactu	rer/Virtual Manufa	
		cturer Permit v
		cturer Permit v
I hereby certify that the above Application for Manufactu		cturer Permit v
I hereby certify that the above Application for Manufactu signed, subscribed and sworn to before me this	day of	cturer Permit v
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Name of Facil	ity:		
Physical Addr	ess of Facility:		
CITY:	STATE:	COUNTY:	ZIP:
Mailing addre	ss of facility:		
CITY:	STATE:	COUNTY:	ZIP:









	Phone Number:
	Fax Number:
	Website Address:
Ι	. Check and complete one of the following and attach proper fee:
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	Proposed date of opening:
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□ <u>Name Change</u> → NO CHARGE

	Numbers and Expirat	tion Dates:
DEA:		Exp. Date:
FDA:		Exp. Date:
Email Address:	<u>aly</u>	
Email Address:	ally.	
	.e	

If yes: please provide explanation below:









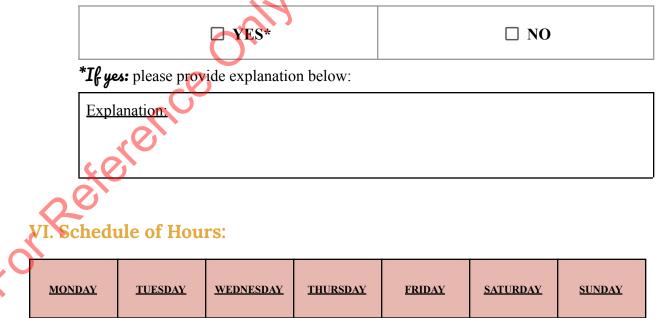


Explanation:

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□ YES*	
*If yes: please provide explanation below:	ico
Explanation:	299.

3. Has the applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever been convicted under federal, state and/or local laws relating to drugs, including drug samples and controlled substances?













OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
		I		I	I	Or
/II. Iden	ntify the P	harmacist	-In-Cha	arge:	•	6
Name:				License No.:	ð	
	201 KAR 2:20)5 requires pharm	nacists-in-ch	arge to notify the Bo	oard of all person	nnel changes.
				5	S×	
/III. Ow	nership:			it r	•	
	-	v registere	d with 1	hekentuck	v Secretar	v of State?
	e Proprietor				,	J
	tnership					
	-	X	Υ.			
	rporation					
□ Oth						
				4 60		
\mathbf{X}	Name and	d title for	each ow	vner/officer/	/manager,	including
S.	professio	nal design	nation (e	e.g. Pres. Joh	n Jones, N	I.D.):
Name:				Tit	le:	
Name:				Tit	le:	
Name:				Tit	le:	
Name:				Tit	e.	









Name:		Title:
Name:		Title:
	(Use supplemental information	on page if necessary)
IX Has thi	s facility had an FDA or thi	rd-party inspection?
17X. 1145 UII	S facility had all PDA of this	ru party inspection:
	□ YES*	
*If yes: please	provide a copy of the inspection repo	ort
-		No.
		Continue Destat
	Supplemental Info	mation Page:
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signed, subscribed and sworn to before me this	day of	, 20
10 ¹		
By:		
Signature:		
My Commission Expires	State of	
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		cturer Permit v
		cturer Permit v
I hereby certify that the above Application for Manufactu		cturer Permit v
I hereby certify that the above Application for Manufactu signed, subscribed and sworn to before me this	day of	cturer Permit v
I hereby certify that the above Application for Manufactu signed, subscribed and sworn to before me this	_day of	cturer Permit v









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Renewal Application to Operate as a Manufacturer or Virtual Manufacturer

Enclose a check or money order for \$150.00, made payable to 'Kentucky State Treasurer' Treasurer' or pay online at <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>. Please print legibly and complete this application; including the required original signature and return no later than September 30th. All renewals received after September30th will be assessed a delinquent fee of \$150.00 pursuant to 201 KAR 2:050, Section 1(14).













CITY:	STATE:	COUNTY:	ZIP:
Mailing address of fact	ility:		
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			noit
Phone Number:			dicat
Fax Number:		, P	84
Website Address:		mil	
I. Registration Nu	Imberstand	Expiration Dates	
DEA Registration No.:	O		Exp. Date:
-	7		
FDA Registration No.:	2		Exp. Date:
FDA Registration No.:		acility Contact Pe	
FDA Registration No.:			









IV. Identify the Pharmacist-in-Charge:

201 KAR 2:205 requires pharmacists-in	n-charge to notify the Board of all personnel changes.
	$\mathbf{O}^{\mathbf{V}}$
V. Ownership:	
- ITour is this facility posiston	ad with the Wanter alm Sagnetic Of State?
How is this facility register	ed with the Kentucky Secretary of State?
□ Sole Proprietor	\$\$C0
□ Partnership	
\Box LLC	NOX
□ Corporation	
□ Other	
	- Jon.
VI: Have you had a license/j	permit disciplined by any other agency or
has your PIC been disciplin	permit disciplined by any other agency or ed by any other agency which you have no
has your PIC been disciplin	ed by any other agency which you have no
has your PIC been discipling previously reported to this	ed by any other agency which you have no
has your PIC been disciplin	ed by any other agency which you have no
has your PIC been discipling previously reported to this CXES*	ed by any other agency which you have not Board?
has your PIC been discipling previously reported to this VES* *If yes: please provide explanation be	ed by any other agency which you have not Board?
has your PIC been discipling previously reported to this CXES*	ed by any other agency which you have not Board?
has your PIC been discipling previously reported to this VES* *If yes: please provide explanation be	ed by any other agency which you have not Board?

VII. Schedule of Hours:









MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	<u>SUNDAY</u>
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
	st of state,	districts, or	territorie	es in which	icalle	

VIII. List of state, districts, or territories in which licensed/permitted:

:

IX. Has this facility had an FDA or third-party inspection?

□ YES □ NO *If yes: please provide a copy of the inspection report. Forberer











Changes in the above information must be submitted in writing with the appropriate application fee to the Board office within thirty (30) days.

The Board may refuse to issue or renew a license/permit or suspend, temporarily suspend, revoke, fine or reasonably restrict the license/permit holder for knowingly making or causing to be made any false, fraudulent or forged statement in connection with an application for a permit. See KRS 315.121.

I hereby certify that the foregoing is true and correct to the best of my knowledge. If the registration herein applied for is granted, I certify that this business will be conducted in full compliance with all applicable federal and state laws and that I will make available any or all records required by law to the extent authorized by law.

Signature of Pharmacist-in-Charge:

signed, subscribed and sworn to before me this	_day of,	20
By:		
Signature:		
My Commission Expires	State of	<u></u> /
nature of Owner:	E	Date:
I hereby certify that the above Application for Manufact	urer/Virtual Manufactu	arer Permit Renewal w
5 5 11		
signed, subscribed and sworn to before me this	day of	, 20
30		, 20
signed, subscribed and sworn to before me this		, 20











Date:

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



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CITY:	STATE:	COUNTY:	ZIP:
Mailing address of fact	ility:		
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			noit
Phone Number:			dicat
Fax Number:		, P	84
Website Address:		mil	
I. Registration Nu	Imberstand	Expiration Dates	
DEA Registration No.:	O		Exp. Date:
-	7		
FDA Registration No.:	2		Exp. Date:
FDA Registration No.:		acility Contact Pe	
FDA Registration No.:			









IV. Identify the Pharmacist-in-Charge:

	n-charge to notify the Board of all personnel changes.
	$\mathbf{O}^{\mathbf{V}}$
V. Ownership:	
How is this facility register	ed with the Kentucky Secretary of State?
now is this facility registered	ed with the Kentucky Secretary of State:
□ Sole Proprietor	i CC
□ Partnership	-ON
\Box LLC	NOX.
□ Corporation	· * ***
□ Other	
VI: Have you had a license/I	permit disciplined by any other agency or
has your PIC been discipline	d by any other agency which you have not
	d by any other agency which you have not
has your PIC been discipline previously reported to this l	d by any other agency which you have not Board?
has your PIC been discipline	d by any other agency which you have not
has your PIC been discipline previously reported to this CES*	by any other agency which you have not Board?
has your PIC been discipline previously reported to this VES* *If yes: please provide explanation bel	by any other agency which you have not Board?
has your PIC been discipline previously reported to this CES*	by any other agency which you have not Board?
has your PIC been discipline previously reported to this VES* *If yes: please provide explanation bel	by any other agency which you have not Board?

VII. Schedule of Hours:









MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	<u>SUNDAY</u>
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
	st of state,	districts, or	territorie	es in which	icalle	

VIII. List of state, districts, or territories in which licensed/permitted:

:

IX. Has this facility had an FDA or third-party inspection?

□ YES □ NO *If yes: please provide a copy of the inspection report. Forberer











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Signature of Pharmacist-in-Charge:

signed, subscribed and sworn to before me this	_day of,	20
By:		
Signature:		
My Commission Expires	State of	<u></u> /
nature of Owner:	E	Date:
I hereby certify that the above Application for Manufact	urer/Virtual Manufactu	arer Permit Renewal w
5 5 11		
signed, subscribed and sworn to before me this	day of	, 20
50°		, 20
signed, subscribed and sworn to before me this		, 20











Date:

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 Special Limited Pharmacy Permit Medical Gas

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>. 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 Informa	tion:	SUD		
Name of Facility:	OUL			
Physical Address of Fa	ncility:			
CITY:	STATE:	COUNTY:	ZIP:	
Mailing address of fac	ility:			
CITY:	STATE:	COUNTY:	ZIP:	











Email:	
Phone number:	•
Fax number:	
Website Address:	
II. Check and complete one of the	following and attach proper fee:
□ <u>New Facility</u> → \$150.00	itAr
Proposed date of opening:	10n
(Filed with board 30 d	lays in advance of opening)
OR Current Permit No. :	Exp. Date:
(In State where	re presently located)
□ <u>Change of Ownership</u> → \$150.0 Proposed date of Acquisition:	0

(Confirmation statement of previous owner must be attached)











□ <u>Change of Address/Location</u> → \$150.00

Date of Proposed Relocation:	
Previous Address:	
□ <u>Name Change</u> → NO CHAR(GE ALON
Previous Name:	dice
	PPr
III. Ownership:	
How is the facility registered	d with the Secretary of State?
□ Sole Proprietor	Su
Partnership	
)
\Box Corporation	
□ Other	
* * Name and title for e	ach owner/officer/member, including
	tion (e.g. Pres. John Jones, PharmD):
Name:	Title:











Name:	Title:	
Name:	Title:	
(Use su	ipplemental information page if necessary)	

IV. Has the pharmacy or any owners individually been subject to discipline in any jurisdiction? If so, please provide the state, case number and summary of discipline assessed.

□ YES*	I NO
*If yes: please attach statement	<u>N66</u>
V. Pharmacist in Charge:	tomit,
Name:	KY License No.:
Kontucky Pharmacy Population 201	K P 2:205 requires the Pharmanist in charge to notify the

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.

VI. Schedule of Hours:

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	<u>SATURDAY</u>	SUNDAY
	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
X	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

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











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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.

ginal Signature of Pharmacist in Charge:	Date:
I hereby certify that the above Application for Pharmac	y Permit was signed, subscribed and
sworn to before me thisday of	, 20
By:	
Signature:	
My Commission Expires	_State of
	Data
ginal Signature of Owner:	Date:
	aller /
ginal Signature of Owner: I hereby certify that the above Application for Pharmac sworn to before me thisday of _	y Permit was signed, subscribed and
I hereby certify that the above Application for Pharmac	y Permit was signed, subscribed and
	y Permit was signed, subscribed and











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Name of Facility:	OUL			
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Fax number:	
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OR Current Permit No. :	Exp. Date:
(In State where	re presently located)
□ <u>Change of Ownership</u> → \$150.0 Proposed date of Acquisition:	0

(Confirmation statement of previous owner must be attached)











□ <u>Change of Address/Location</u> → \$150.00

Date of Proposed Relocation:	
Previous Address:	
□ <u>Name Change</u> → NO CHAR(GE ALON
Previous Name:	dice
	PPr
III. Ownership:	
How is the facility registered	d with the Secretary of State?
□ Sole Proprietor	Su
Partnership	
)
\Box Corporation	
□ Other	
* * Name and title for e	ach owner/officer/member, including
	tion (e.g. Pres. John Jones, PharmD):
Name:	Title:











Name:	Title:	
Name:	Title:	
(Use su	ipplemental information page if necessary)	

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V. Pharmacist in Charge:	tomit,
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	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	<u>SATURDAY</u>	SUNDAY
	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
X	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

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











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ginal Signature of Pharmacist in Charge:	Date:
I hereby certify that the above Application for Pharmac	y Permit was signed, subscribed and
sworn to before me thisday of	, 20
By:	
Signature:	
My Commission Expires	_State of
	Data
ginal Signature of Owner:	Date:
	an I and
ginal Signature of Owner: I hereby certify that the above Application for Pharmac sworn to before me thisday of _	y Permit was signed, subscribed and
I hereby certify that the above Application for Pharmac	y Permit was signed, subscribed and
	y Permit was signed, subscribed and











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 Special Limited Pharmacy Permit ⇒ Medical Gas Renewal

Enclose a check or money order for \$150.00, made payable to 'Kentucky State Treasurer' or pay online at <u>https://secure.kentucky.gov/formservices/Pharmacy/Virtual Terminal</u>. Please print legibly and complete this application; including the required original signature and return to the Board office 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.	Facility	Information

Name of Facilit	y:			
Kentucky Perm	it Number:			
Address of Faci	lity:			
CITY:	STATE:	COUNTY:	ZIP:	
Email:				









Phone number:	
Fax number:	
Website Address:	On
	no:
II. Ownership:	icali
How are you registered with th	he Kentucky Secretary of State?
□ Sole Proprietor	
□ Partnership	
□ Corporation	
□ Other	S
+ Name and title for and	h owner/officer/member, including
	n(e.g. Pres. John Jones, PharmD):
Name:	Title:
Name:	Title:
Name:	Title:
Name: Name:	Title:









III. Has the pharmacy or any owners individually been subject to discipline in any jurisdiction? If so, please provide the state, case number and summary of discipline assessed.

Name:			KY	License No.	icol	•
	harmacy Regulat fourted	en (14) calendar (e Board within
MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
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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. [If applicable, this pharmacy is currently licensed and in good standing in all states of licensure].

ginal Signature of Pharmacist in Charge:	Date:
I hereby certify that the above Application for Ph	narmacy Permit Renewal was signed, subscri
and sworn to before me this	day of , 20 .
By:	
Signature:	
My Commission Expires	State of
Othe	
ginal Signature of Owner:	
ginal Signature of Owner.	Date:
	Date:
I hereby certify that the above Application for Pl	narmacy Permit Renewal was signed, subscri
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I hereby certify that the above Application for Ph and sworn to before me this By:	narmacy Permit Renewal was signed, subscri day of, 20
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I hereby certify that the above Application for Ph and sworn to before me this By: Signature:	narmacy Permit Renewal was signed, subscri

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By:	day of, 2	was signed, subscribed

KENTUCKY BOARD OF PHARMACY State Office Building Annex, Suite 300 125 Holmes Street Frankfort KY 40601

Memorandum of Understanding and Agreement

I have read, understand, and agree to abide by KRS Chapters 315, 217, and 218A; 201 KAR Chapter 2; and 902 KAR Chapter 55. In addition, I specifically acknowledge and agree to the following:

I understand that the Board of Pharmacy ("board") may refuse to issue or renew a license or permit, or may suspend, temporarily suspend, revoke, fine, place on probation, reprimand, reasonably restrict, or take any combination of actions against a licensee or permit holder for knowingly making or causing to be made any false, fraudulent, or forged statement or misrepresentation of a material fact in securing issuance or renewal of a license or permit. **KRS 315.121(1) (e)**

Every out-of-state pharmacy granted an out-of-state pharmacy permit by the board shall disclose to the board the location, names and titles of all principal corporate officers and all pharmacists who are dispensing prescription drugs to residents of the Commonwealth. A report containing this information shall be made to the board on an annual basis and within thirty (30) days after any change of office, corporate officer, or pharmacist. KRS 315.0351(2)

The pharmacist-in-charge shall be responsible for providing written notification to the board within fourteen 14 days of any change in the employment of the pharmacist-in-charge, staff pharmacists, and pharmacy hours. 201 KAR 2:205, Section 2(3)(d)

The out-of-state pharmacy shall maintain at all times a valid unexpired permit, license, or registration to conduct the pharmacy in compliance with the laws of the jurisdiction in which it is a resident.

KRS 315.0351(3)

The out-of-state pharmacy granted a permit shall submit to the board a copy of any subsequent inspection report on the pharmacy conducted by the regulatory or licensure body of the jurisdiction in which it is located. KRS 315.0351(3)

Every out-of-state pharmacy granted an out-of-state pharmacy permit shall maintain records of any controlled substances or dangerous drugs or devices dispensed to patients in Kentucky so that the records are readily retrievable from the records of other drugs dispensed. KRS 315.0351(4)

Records for all prescriptions delivered into Kentucky shall be readily retrievable from the other prescription tecords of the out-of-state pharmacy. KRS 315.0351(5)

Each out-of-state pharmacy shall, during its regular hours of operation, but not less than six (6) days per week and for a minimum of forty (40) hours per week, provide a toll-free telephone service directly to the pharmacist in charge of the out-of-state pharmacy and available to both the patient and each licensed and practicing in-state pharmacist for the purpose of facilitating communication between the patient and the Kentucky pharmacist with access to the patient's prescription records. The toll-free number shall be placed on a label affixed to each container of drugs dispensed to patients within Kentucky. KRS 315.0351(6)

Each out-of-state pharmacy shall have a pharmacist in charge who is licensed to engage in the practice of pharmacy in Kentucky that shall be responsible for compliance by the pharmacy. **KRS 315.0351(7)**

Each out-of-state pharmacy shall comply with KRS 218A.202:

- Every dispenser who is licensed by the Kentucky Board of Pharmacy shall report required data to the Cabinet for Health Services in a timely manner.
 KRS 218A.202(3)
- Data for each controlled substance shall include but not be limited to patient identifier, drug dispensed, date of dispensing, quantity dispensed, prescriber, and dispenser. KRS 218A.202(4)
- The data shall be provided in the electronic format specified by the Cabinet for Health Services unless a waiver has been granted by the cabinet to an individual dispenser. KRS 218A.202(5)
- Knowing failure by a dispenser to transmit data to the cabinet as required shall be a Class A misdemeanor.
 KRS 218A.202(9)

Any out-of-state pharmacy doing business, primarily or exclusively by use of the Internet shall, prior to obtaining a permit, receive and display in every medium in which it advertises itself a seal of approval for the National Association of Boards of Pharmacy certifying that it is a Verified Internet Pharmacy Practice Site (VIPPS). VIPPS certification shall be maintained and remain current. KRS 315.0351(9)

Any out-of-state pharmacy doing business primarily or exclusively by use of the Internet shall certify the percentage of its annual business conducted via the Internet and submit such supporting documentation as requested by the board, and in a form or application required by the board, when it applies for permit or renewal. KRS 315.0351(10)

I hereby certify that I have read and agree to abide by the provisions referenced within this *Memorandum of Understanding and Agreement*.

Signature of Pharmacist-in-Charge	orandum of Understand	ing and Agreement was signed, subscribe	ed and sworn to befo
thisday of		5 5 5	
e e		Signature	
My Commission Expires	State of		
<u>kO</u>			
Signature of Owner			
hereby certify that the above Memory this day of		ng and Agreement was signed, subscribe	ed and sworn to befo
		Signature	



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			culo.		
	I. Facility Informa	tion:	-		
	Name of Facility:	OUL	3		
	Physical Address of Fa	cility:			
	CITY:	STATE:	COUNTY:	ZIP:	
	Mailing address of fact	ility:			
С	CITY:	STATE:	COUNTY:	ZIP:	











Email:		
Phone number:		•
Fax number:		
Website Address:		70:
II. Check and complete on □ <u>New Facility</u> → \$150.00		and attach proper fee:
Current Permit No. :	ionn	Exp. Date:
(h	In State where presently loca	ted)
Proposed date of Acquisition:		
Name of Previous Owner(s): (Confirmation s	statement of previous owner	must be attached)
Change of Address/Loc		











Date of Proposed Relocation:

Previous Address:

□ <u>Name Change</u> → NO CHARGE

nontine JICOIL Previous Name: **III. Ownership:** etary of State? How is the facility registered with the Sec □ Sole Proprietor MW-S' □ Partnership \Box LLC □ Corporation \Box N/A \star \star Name and the for each owner/officer/member, including professional designation (e.g. Pres. John Jones, PharmD): Name: Title: Name Title: Name: Title: Name: Title: Name: Title:











Title:

(Use supplemental information page if necessary)

IV. Has the pharmacy or any owners individually been subject to discipline in any jurisdiction? If so, please provide the state, case number and summary of discipline assessed.

□ YES*						
*If yes: please attach statement					iCo	
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	acist in Ch	laige.				
Name:			KY	License No.:		
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TEAM **KENTUCKY**









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I hereby certify that the above Application for Phar	macy Permit was signed, subscribed and
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By:	
Signature:	
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	CITY:	STATE:	COUNTY:	ZIP:	
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Phone number:	
Fax number:	
Website Address:	0
II. Ownership:	all
How are you registered with	the Kentucky Secretary of State?
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ginal Signature of Pharmacist in Charge:		Date:
I hereby certify that the above Application for Pl	narmacy Permit Renewal v	vas sign <mark>ed</mark> , subscribed
and sworn to before me this	day of,	20
By:	O	
Signature:		
My Commission Expires	State of	
ginal Signature of Owner:	WE	Date:
rinal Signature of Owner:	WE	Date:
	narmacy Permit Renewal v	5
I hereby certify that the above Application for P		vas signed, subscribed
		vas signed, subscribed
I hereby certify that the above Application for Pl and sworn to before me this		vas signed, subscribed
I hereby certify that the above Application for Pl and sworn to before me this		vas signed, subscribed
I hereby certify that the above Application for Pl and sworn to before me this By:		vas signed, subscribed
I hereby certify that the above Application for Pl and sworn to before me this By: Signature:	day of, 2	vas signed, subscribec
I hereby certify that the above Application for Pl and sworn to before me this By:	day of, 2	vas signed, subscribec
By: Signature:	day of, 2	vas signed, subscribed

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 <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>. 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 Info	ormation:	SUD		
	Name of Pharmacy	OULA			
	Physical Address o	f Pharmacy:			
	CITY:	STATE:	COUNTY:	ZIP:	
	Mailing Address of	Pharmacy:			
Ċ	CITY:	STATE:	COUNTY:	ZIP:	
	Email Address:				











	Phone Number:	
	Fax Number:	
	Toll Free Number:	
	Website Address:	
1	II. Check and complete one of the following and article proper fee: □ <u>New Pharmacy</u> → \$150.00	
	Proposed date of Opening:	
	(Filed with board 30 days in advance of opening) □ <u>Change of Ownership</u> → \$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:	
<u> </u>		







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Previous Name	::		atil	
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How is the pl □ Sole Prop □ Partnersh □ LLC	harmacy register prietor hip	red with the Kentu	X cky Secretary of St	tate
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How is the pl ☐ Sole Proy ☐ Partnersh ☐ LLC ☐ Corporat ☐ Not App ★★pl	harmacy register prietor hip tion licable ease provide the fo	Subra Subr	for each owner/offic	er,











	Address(Home):		
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	Phone number(Home):		70.
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	Name:	, PQX	Title:
	Address(Business):	omit	
	CITY: STATE:	COUNTY: ZIP:	
	Address(Home):		
	CITY: STATE:	COUNTY: ZIP:	
	Phone number(Business):		
	Phone number(Home):		
1 of the	Social Security Number:	Date of Birth:	
3.			1
	Name:		Title:











	Address(Busi	ness):			
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	Name:		SUP	Title	:
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5.

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	Phone number(Business):		D66.	
	Phone number(Home):	mit	•	
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		(Use supplement	ntal information	page if necessary	7)	
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*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	
Does the pharmacy dispense any	prescriptions to citizens of the
nmonwealth of Kentucky that ha	ave been referred to the pharmacy
whole or in part, by an outside ag	gent (e.g. internet broker)?
□ YES*	D NO
yes: Approximately how many anticipated o	r actual prescriptions dispensed to citizens of
Commonwealth of Kentucky per calendar mo	onth are referred to the pharmacy by agent(s).
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★ ★ List the name, address, phone	number, and email address of all
ager	
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Address	
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CITY: STATE: COU	JNTY: ZIP:
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Email Address:	JNTY: ZIP:
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	Phone Number:	U			
	4.Name:				
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	Email Address:				











Phone Number:

	5.Name:
	Address:
	CITY: STATE: COUNTY: ZIP:
	Email Address:
	Phone Number:
	(Use supplemental information page if necessary)
	culot.
	oes the pharmacy employ, ontract with, or compensate directly
	directly physicians to authorize prescriptions for citizens of the monwealth of Kentucky
*If yes	please provide the following information for all physicians:
	1.Name:
.8	Business Address:
For	CITY: STATE: COUNTY: ZIP:
•	Business Phone:











	Email Address:	
	DEA Number:	State(s) of licensure:
	Social Security Number:	Date of Birth:
	2. Name:	ail ⁰
	Business Address:	olice
	CITY: STATE: CO	UNTY: ZIP:
	Business Phone:	omit
	Email Address:	
	DEA Number:	State(s) of licensure:
	Social Security Number:	Date of Birth:
	3.Name:	
6	Business Address:	
4 0'	CITY: STATE: CO	UNTY: ZIP:
	Business Phone:	











	Email Address:	
	DEA Number:	State(s) of licensure:
	Social Security Number:	Date of Birth:
	4.Name:	jil0'
	Business Address:	olice
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	Business Phone:	onit
	Email Address:	
	DEA Number:	State(s) of licensure:
	Social Security Number:	Date of Birth:
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	Business Phone:	











	DEA Number:	State(s) of licensure:
	Social Security Number:	Date of Birth:
l	(Use supplemental	information page if necessary)
ם ווא	oes the pharmacy ship an	y prescriptions to the citizens of the
		der any name or return address oth
han t	the information of the pha	rmacy seeking or renewing a permi
orovi	ded with this application?	DR'
	□ YES*	
If ues:	Please provide a list of the addition	al pharmacy name(s) or return addresses that the
• •		he Commonwealth of Kentucky and why.
¢	(Use supplemental	information page if necessary)
8	(Use supplemental	information page if necessary)







TEAM TEAM TEAM TEAM TEAM

Kentucky and the percentage of time each service is utilized in Kentucky.

Delivery Service Utilized:	Percentage of Time:
	U.
	Call
	Q
(Use supplemental information pa	ge if necessary)
XIV. Are you permitted in other states?	
SY	
□ YES*	
*If yes: please list below	
e e e e e e e e e e e e e e e e e e e	
XV. Has the pharmacy or pharmacist in c	harge been subject to
liscipline in any jurisdiction? If so, pleas	
number and summary of discipline asses	-
□ YES*	







TEAM **KENTUCKY**

Form 9/2023

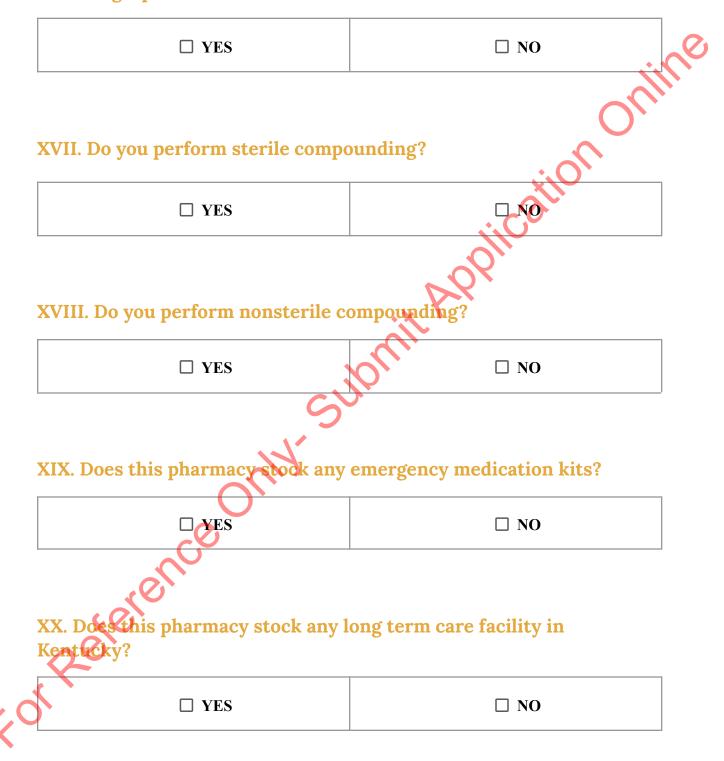
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XVI. Has the pharmacy shipped drugs into Kentucky prior to obtaining a permit?













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

	OU
XII. Date of last controlled substa	nce inventory:
Date:	
	<u>n</u> pp///
Supplemental In	formation Page:
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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:

on-Resident Pharmad	ey Permit was signed,
d <u>ay of</u>	<u></u>
2	
State of	
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on=Resident Pharma	cy Permit was signed,
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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 nderstan. AQR SUDMIT SUD SUDMIT SUDMIT SUD SUDMIT SUDMIT SUDMIT SUDMIT SUDMIT S preceding the application date
 - Copy of notarized Memorandum of Understanding and Agreement











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

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	I. Pharmacy Info	ormation:	SUD		
	Name of Pharmacy	OULA			
	Physical Address o	f Pharmacy:			
	CITY:	STATE:	COUNTY:	ZIP:	
	Mailing Address of	Pharmacy:			
Ó	CITY:	STATE:	COUNTY:	ZIP:	
	Email Address:				











	Phone Number:	
	Fax Number:	
	Toll Free Number:	
	Website Address:	
I	I. Check and complete one of the following and attach proper fee: □ <u>New Pharmacy</u> → \$150.00	
	Proposed date of Opening:	
	(Filed with board 30 days in advance of opening) □ <u>Change of Ownership</u> → \$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	
5	Date of Proposed Relocation:	







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CITY:	STATE:	COUNTY:	ZIP:	
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	Address(Home):		
	CITY: STATE:	COUNTY: ZIP:	
	Phone number(Business):		<u>nim</u>
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	Social Security Number:	Date of Birth:	Call
2.			
	Name:	, PQX	Title:
	Address(Business):	omit	
	CITY: STATE:	COUNTY: ZIP:	
	Address(Home):		
	CITY: STATE:	COUNTY: ZIP:	
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1 of the	Social Security Number:	Date of Birth:	
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	Address(Busi	ness):			
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IV. 1	(Use suppleme Pharmacist-In-Charge (P.I	ental information page if	`necessary)	
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				Licen	se No. :	
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	ntral Fill		Oxygen		🗆 Veterin	ary	

*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?

Does the pharmacy dispense any	prescriptions to citizens of the
•	ave been referred to the pharmacy
whole or in part, by an outside ag	gent (e.g. internet broker)?
□ YES*	Ö NO
es: Approximately how many anticipated of	r actual prescriptions dispensed to citizens of
Commonwealth of Kentucky per calendar mo	onth are referred to the pharmacy by agent(s).
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	Email Address:				











Phone Number:

	5.Name:
	Address:
	CITY: STATE: COUNTY: ZIP:
	Email Address:
	Phone Number: (Use supplemental information page if necessary)
	oes the pharmacy employ, ontract with, or compensate directly directly physicians to authorize prescriptions for citizens of the
	nonwealth of Kentucky
*If yes	• please provide the following information for all physicians:
	1.Name:
8	Business Address:
40r	CITY: STATE: COUNTY: ZIP:
	Business Phone:











	Email Address:			
	DEA Number:	State(s) of licensure:		
	Social Security Number:	Date of Birth:		
	2. Name:	ail ⁰		
	Business Address:	olice		
	CITY: STATE: CO	UNTY: ZIP:		
	Business Phone:			
	Email Address:			
	DEA Number:	State(s) of licensure:		
	Social Security Number:	Date of Birth:		
	3.Name:			
6	Business Address:			
4 0'	CITY: STATE: CO	UNTY: ZIP:		
	Business Phone:			











	Email Address:		
	DEA Number:	State(s) of licensure:	
	Social Security Number:	Date of Birth:	
	4.Name:	jil0'	
	Business Address:	olice	
	CITY: STATE: COUNTY: ZIP:		
	Business Phone:		
	Email Address:		
	DEA Number:	State(s) of licensure:	
	Social Security Number:	Date of Birth:	
	5.Name:		
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	Business Phone:		











L	DEA Number:	State(s) of licensure:	
	Social Security Number:	Date of Birth:	
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ם ווא	oes the pharmacy ship an	y prescriptions to the circlens of th	
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orovio	ded with this application?	DR.	
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If ues:	Please provide a list of the addition	al pharmacy name(s) or return addresses that the	
• •		the Commonwealth of Kentucky and why.	
	(C)		
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	reter		
¢	(Use supplemental	information page if necessary)	
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Kentucky and the percentage of time each service is utilized in Kentucky.

Delivery Service Utilized:	Percentage of Time:		
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	. Call		
	Q		
(Use supplemental informatio	n page if necessary)		
	<i>(</i>)		
KIV. Are you permitted in other states	ê		
C V			
□ YES*			
*If yes: please list below			
<u> </u>			
XV. Has the pharmacy or pharmacist in	n charge been subject to		
liscipline in any jurisdiction? If so, pla			
number and summary of discipline ass	-		
□ YES*			







TEAM **KENTUCKY**

Form 9/2023

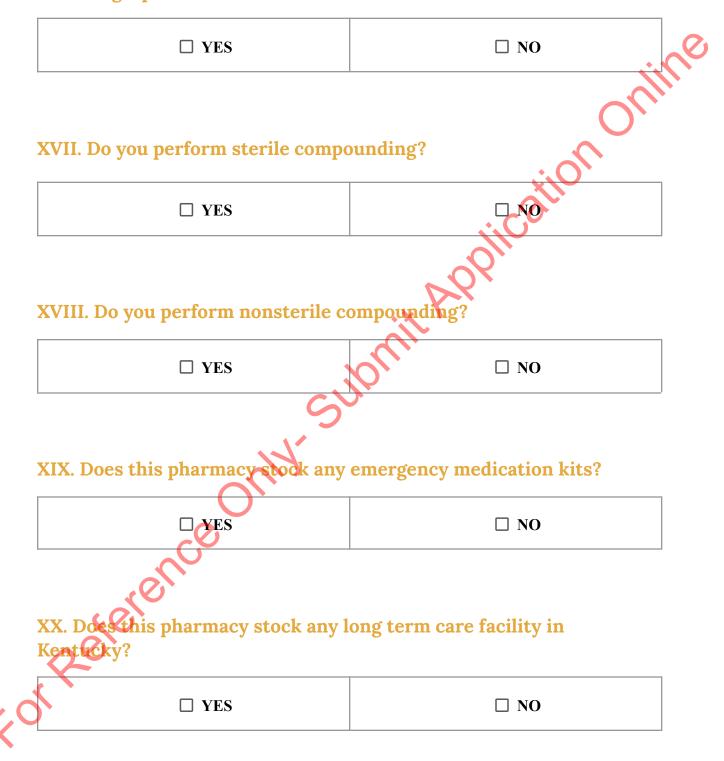
TEAM

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













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

	OU
XII. Date of last controlled substa	nce inventory:
Date:	
	<u>n</u> pp///
Supplemental In	formation Page:
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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 N	Non-Resident Pharma	cy Permit was signed,
subscribed and sworn to before me this	day of	<u>,20</u>
	di.	
By:	<u>, , , , , , , , , , , , , , , , , , , </u>	
Signature:		
My Commission Expires	State of	
ignature of Owner:	EAL	Date:
COBED		
I hereby certify that the above Application for N	Non-Resident Pharma	cy Permit was signed,
subscribed and sworn to before me this	d <u>ay of</u>	, 20 .
By		
Signature:		
My Commission Expires	State of	
	_ 5000 01	·











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 nderstan. AQR SUDMIT SUD SUDMIT SUDMIT SUD SUDMIT SUDMIT SUDMIT SUDMIT SUDMIT S preceding the application date
 - Copy of notarized Memorandum of Understanding and Agreement











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



Non-Resident Application for Special Limited

Pharmacy Permit -> Clinical Practice 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).

]	I. Facility Inforr	nation:	Su		
	Name of Facility:	OUI			
	Kentucky Permit N				
	Physical Address o	f Facility:			
	CITY:	STATE:	COUNTY:	ZIP:	
0	Email Address:				











Fax Number:	
Website Address:	O ⁽
I. Ownership:	ilo.
_	ed with the Kentucky Secretary of State?
Sole Proprietor	
\square Partnership	DY.
\Box LLC	
$\Box Corporation \\\Box N/A$	10 ¹
	CN.
	ch owner/officer/member, including
professional designation	on (e.g. Pres. John Jones, PharmD):
Name:	Title:
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	Title:
Name:	

TEAM **KENTUCKY** TEAM **KENTUCKY** 









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

□ YES*	
<b>f yes:</b> Please explain below	$\int_{O}$
	ation
Pharmacist in Charge (P.I.C.), I chnicians:	Pharmacist(s), Interns and
Name	KY License No.:
	KY License No.:
	KY License No.:
Name	KY License No.:
	KY License No.:
	KY License No.:

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











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<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	THURSDAY	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>	
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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.

ig <mark>nature of Pharmac</mark> ist-in-Charge:		Date:
I hereby certify that the above Renewal Applic	cation for Pharmacy	Permit was signed, subscribe
and sworn to before me this		
By:	JOI	
Signature:	E EA	1.34
My Commission Expires	State o	of
gnature of Owner:		Date:
I hereby certify that the above Renewal Applic and sworn to before me this By:		
Signature:		
My Commission Expires	State o	
		Form 9/20









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



# Non-Resident Application for Special Limited

### Pharmacy Permit -> Clinical Practice 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).

]	I. Facility Inforr	nation:	Su		
	Name of Facility:	OUI			
	Kentucky Permit N				
	Physical Address o	f Facility:			
	CITY:	STATE:	COUNTY:	ZIP:	
0	Email Address:				











Fax Number:	
Website Address:	O ⁽
I. Ownership:	ilo.
_	ed with the Kentucky Secretary of State?
Sole Proprietor	
$\square$ Partnership	DY.
$\Box$ LLC	
$\Box Corporation \\\Box N/A$	10 ¹
	CN.
	ch owner/officer/member, including
professional designation	on (e.g. Pres. John Jones, PharmD):
Name:	Title:
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	Title:
Name:	

TEAM **KENTUCKY** TEAM **KENTUCKY**









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

□ YES*	
f yes: Please explain below	\int_{O}
	ation
Pharmacist in Charge (P.I.C.), I chnicians:	Pharmacist(s), Interns and
Name	KY License No.:
	KY License No.:
	KY License No.:
Name	KY License No.:
	KY License No.:
	KY License No.:

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











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<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	THURSDAY	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>	
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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.

ig <mark>nature of Pharmac</mark> ist-in-Charge:		Date:
I hereby certify that the above Renewal Applic	cation for Pharmacy	Permit was signed, subscribe
and sworn to before me this		
By:	JOI	
Signature:	E EA	1.34
My Commission Expires	State o	of
gnature of Owner:		Date:
I hereby certify that the above Renewal Applic and sworn to before me this By:		
Signature:		
My Commission Expires	State o	
		Form 9/20









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



Enclose a check or money order for \$150.00, made payable to 'Kentucky State Treasurer' or pay online at <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>. Please print legibly and complete this application; including the required original signature and return no later than June 30th.

I. Facility Informat	ion:	omit		
Name of Facility:	(SUP		
Kentucky Permit No.:	ally.			
Physical Address of Fac	pility:			
CITY:	STATE:	COUNTY:	ZIP:	
Email Address:				
Phone Number:				
Fax Number:				











II. Ownership:

ine How is the pharmacy registered with the Kentucky Secretary of Star

- \Box Sole Proprietor
- □ Partnership
- \Box LLC
- □ Corporation
- \Box N/A

plication \star \star Name and title for each owner/officer/member, including any professional designation (e.g. Pres, John Jones, PharmD):

Name:	C	Title:	
Name:		Title:	
Name:		Title:	
Name:	04.	Title:	
Name:	C ^O	Title:	
Name:		Title:	
eter	(Use supplemental in:	formation page if necessary)	
JII. Schedule of	Hours		
The benedule of	110415.		
(PIC must	notify the Board within fourte	en (14) davs of any changes i	n scheduled hours)
	notify the Board within fourte	in (1+) days of any changes i	

	<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>	
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lice	Nam	etered wit		License/Re Pharmacist,	egistration I Pharmacist acy Technic	Intern or
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3.						

TEAM **KENTUCKY** TEAM **KENTUCKY**











⁽Use supplemental information page if necessary)

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

Name:		Title:	
Address:	24		
CITY:	STATE.	COUNTY:	ZIP:
	nce		
Name:	0	Title:	
Address:			
CITY:	STATE:	COUNTY:	ZIP:











Form 9/2023

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Address:			
CITY:	STATE:	COUNTY:	ZIP:
Name:		Title:	ation
Address:			<u>QIIC</u>
CITY:	STATE:	COUNTY:	ZIP:
Name:		Title:	
Address:	anty		
CITY:	STATE:	COUNTY:	ZIP:
.(0	(Use suppleme	ntal information page if necessar	ry)
V. Discipline	:		
	harmacy license/per ed to this Board?	mit disciplined by any age	ency which you have not
	□ YES*		

*If yes: Please explain below









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V. 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*	
* If yes: Please provide a list of the additional ph pharmacy ships prescriptions to citizens of the C	
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<u> </u>	
(Use supplemental inform VI. List the methods of deliver serv utilized to deliver prescriptions to Kentucky and the percentage of tin Kentucky.	ices (e.g. USPS, UPS, FedEx, etc) citizens of the Commonwealth of

Delivery Service Utilized:

Percentage of Time:



:







			ON
	(Use supplemental if	nformation page if necessa	
VII. Are you perm	itted in other s	states?	<u>R</u> .
	YES*	itr	
*If yes: please list below	V	<i>10</i>	
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	OUIN		
Reference	S.		
coror			















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iginal Signature of Pharmacist-in-Charge:	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	Date:
I hereby certify that the above Application for Non-Re	esident Special Limit I	Pharmacy Permit was signe
subscribed and sworn to before me this		
By:	, ·	
Signature:		
My Commission Expires	State of	
iginal Signature of Owner:	EFR	Date:
I hereby certify that the above Application for Non	-Resident Special Lim	ited Pharmacy Permit was
signed, subscribed and sworn to before me this _	day of	, 20
By:		
Signature:		
Signature: My Commission Expires	State of	
	State of	 Form 9/2

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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



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I. Facility Informat	ion:	omit		
Name of Facility:	(SUP		
Kentucky Permit No.:	ally.			
Physical Address of Fac	pility:			
CITY:	STATE:	COUNTY:	ZIP:	
Email Address:				
Phone Number:				
Fax Number:				











II. Ownership:

ine How is the pharmacy registered with the Kentucky Secretary of Star

- \Box Sole Proprietor
- □ Partnership
- \Box LLC
- □ Corporation
- \Box N/A

plication \star \star Name and title for each owner/officer/member, including any professional designation (e.g. Pres, John Jones, PharmD):

Name:	C	Title:	
Name:		Title:	
Name:		Title:	
Name:	04.	Title:	
Name:	C ^O	Title:	
Name:		Title:	
eter	(Use supplemental in:	formation page if necessary)	
JII. Schedule of	Hours		
The benedule of	110415.		
(PIC must	notify the Board within fourte	en (14) davs of any changes i	n scheduled hours)
	notify the Board within fourte	in (1+) days of any changes i	

	<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>	
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CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
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	-	al	l pharmacist cha	nges.	-] calendar days of
		e comple			ees	
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3.						

TEAM **KENTUCKY** TEAM **KENTUCKY**











⁽Use supplemental information page if necessary)

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

Name:		Title:	
Address:	24		
CITY:	STATE.	COUNTY:	ZIP:
	nce		
Name:	0	Title:	
Address:			
CITY:	STATE:	COUNTY:	ZIP:











Form 9/2023

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Address:			
CITY:	STATE:	COUNTY:	ZIP:
Name:		Title:	ation
Address:			<u>QIIC</u>
CITY:	STATE:	COUNTY:	ZIP:
Name:		Title:	
Address:	anty		
CITY:	STATE:	COUNTY:	ZIP:
.(0	(Use suppleme	ntal information page if necessar	ry)
V. Discipline	:		
	harmacy license/per ed to this Board?	mit disciplined by any age	ency which you have not
	□ YES*		

*If yes: Please explain below









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V. 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*	
* If yes: Please provide a list of the additional ph pharmacy ships prescriptions to citizens of the C	
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(Use supplemental inform VI. List the methods of deliver serv utilized to deliver prescriptions to Kentucky and the percentage of tin Kentucky.	ices (e.g. USPS, UPS, FedEx, etc) citizens of the Commonwealth of

Delivery Service Utilized:

Percentage of Time:



:







			ON
	(Use supplemental if	nformation page if necessa	
VII. Are you perm	itted in other s	states?	<u>R</u> .
	YES*	itr	
*If yes: please list below	V	<i>10</i>	
:	C		
	OUIN		
Reference	S.		
coror			















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iginal Signature of Pharmacist-in-Charge:	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	Date:
I hereby certify that the above Application for Non-Re	esident Special Limit I	Pharmacy Permit was signe
subscribed and sworn to before me this		
By:	, ·	
Signature:		
My Commission Expires	State of	
iginal Signature of Owner:	EFR	Date:
I hereby certify that the above Application for Non	-Resident Special Lim	ited Pharmacy Permit was
signed, subscribed and sworn to before me this _	day of	, 20
By:		
Signature:		
Signature: My Commission Expires	State of	
	State of	 Form 9/2

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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 <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>. 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.

. Facility Inform	ation:	culo.		
Name of Facility:		5		
Physical Address of I	Facility:			
CITY:	STATE:	COUNTY:	ZIP:	
Mailing Address of F	`acility:			
CITY:	STATE:	COUNTY:	ZIP:	
	Name of Facility: Physical Address of I CITY: Mailing Address of F	Physical Address of Facility: CITY: STATE: Mailing Address of Facility:	Name of Facility: Physical Address of Facility: CITY: STATE: Mailing Address of Facility:	Name of Facility: Physical Address of Facility: CITY: STATE: COUNTY: ZIP: Mailing Address of Facility:











Phone Number:	
Fax Number:	0
Website Address:	
I. Check and complete one of th	he following and attach proper fee:
□ <u>New Facility</u> → \$150.00	. PQY
Proposed date of Opening:	MIL
(Filed with be	pard 30 days in advance of opening)
OR Current Permit No. :	Exp. Date:
(In State w	where presently located)
□ <u>Change of Ownership</u> → \$0	
Proposed date of Acquisition:	
Name of Previous Owner(s):	
(Confirmation statem	nent of previous must be attached)
	-→ \$0

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Date of Proposed Relocation:

Previous Address:

□ <u>Name Change</u> → \$0

Previous Name:

III. Ownership:

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

Subr

\ \

	Sole	Pro	prietor
--	------	-----	---------

- □ Partnership
- \Box LLC
- \Box Corporation
- \Box N/A

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

Name:	C.	Title:		
Address (Ho	ome):			
СІТУ:	STATE:	COUNTY:	ZIP:	











Form 9/2023

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CITY:	STATE:	COUNTY:	ZIP:	
Phone Number(Home):			5
Phone Number(Business):		tion	
Date of Birth:			dicat	
Social Security	Number:	P	<u></u>	
Name:		Title:		
Address (Home):	S		
CITY:	STATE:	COUNTY:	ZIP:	
Address (Busine	ess):			
CITY:	STATE:	COUNTY:	ZIP:	
Phone Number(Home):			





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Social Security	Number:			<u>, , , , , , , , , , , , , , , , , , , </u>
Name:		Title:	Ó	
Address (Home):		ation	
CITY:	STATE:	COUNTY:	ZIP:	
Address (Busine	ess):	aitA		
CITY:	STATE:	COUNTY:	ZIP:	
Phone Number(Home):	<u> </u>		
Phone Number(Business)			
Date of Birth:	nce			
Social Security	Number:			
20				
Name:		Title:		

4









CITY:	STATE:	COUNTY:	ZIP:
Address (Busine	ess):		
CITY:	STATE:	COUNTY:	ZIP:
Phone Number(Home):		tion
Phone Number(Business):		dica
Date of Birth:		P	<i>SK</i>
Social Security	Number:	Mill	
Name:	4	Title:	
Address (Home)			
CITY:	STATE:	COUNTY:	ZIP:
Address (Busine	ess):		
CITY:	STATE:	COUNTY:	ZIP:
Phone Number(Home):		







Date of Birth:				
Social Security Number:				
(Use supplem	nental information page if necessary)			
V. Pharmacist in Charge:	olicatio			
Name:	KY License No.:			
	2:205 requires the Pharmacist in charge to notify the Board within ar days of all pharmacist personnel changes.			
	culo:			
. Name and license/registr	ation number of pharmacy employees:			
Name:	License No. :			
Name:	License No. :			
Name:	License No. :			
Name:	License No. :			
Name	License No. :			
Name:	License No. :			

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











Name:	Title:	
		_ 0
Name:	Title:	ine
	O'	
Name:	Title:	
Name:	Title:	
	22,	
Name:	Title:	
(U	se supplemental information page if necessary)	
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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	<u>THURSDAY</u>	FRIDAY	<u>SATURDAY</u>	<u>SUNDAY</u>
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

 \star Please indicate if closed for lunch:

Υ

until

VIII. Discipline:











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

If yes: Please explain below X. Does the pharmacy ship any press commonwealth of Kentucky under a han the information of the pharmacy rovided with this application?	any name of return address other
commonwealth of Kentucky under a han the information of the pharmac	any name of return address other
commonwealth of Kentucky under a han the information of the pharmac	any name of return address other
commonwealth of Kentucky under a han the information of the pharmac	any name of return address other
□ YES*	
If yes: Please provide a list of the additional phar harmacy ships prescriptions to citizens of the Cor	
Referen	

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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:
	O ^N
	Cal.
	R
(Use supplemental information	page if necessary)
XI. Are you permitted in other states?	
□ YES*	
If yes: please list below	
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REQUIRED DOCUMENTATION MUST BE ENCLOSED

 \Box 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* M Control of the second second











Form 9/2023

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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:

	y of, 20
By:	
Signature:	
My Commission Expires Stat	e of
ature of Owner:	Date:
I hereby certify that the above Application for Non-Resident Spe	cial Limited Pharmacy Permit was
I hereby certify that the above Application for Non-Resident Spectrosection signed, subscribed and sworn to before me thisday	

TEAM TEAM







Form 9/2023

Date:

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 <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>. 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.

. Facility Inform	ation:	culo.		
Name of Facility:		5		
Physical Address of I	Facility:			
CITY:	STATE:	COUNTY:	ZIP:	
Mailing Address of F	`acility:			
CITY:	STATE:	COUNTY:	ZIP:	
	Name of Facility: Physical Address of I CITY: Mailing Address of F	Physical Address of Facility: CITY: STATE: Mailing Address of Facility:	Name of Facility: Physical Address of Facility: CITY: STATE: Mailing Address of Facility:	Name of Facility: Physical Address of Facility: CITY: STATE: COUNTY: ZIP: Mailing Address of Facility:











Phone Number:	
Fax Number:	0
Website Address:	
I. Check and complete one of th	he following and attach proper fee:
□ <u>New Facility</u> → \$150.00	. PQY
Proposed date of Opening:	MIL
(Filed with be	pard 30 days in advance of opening)
OR Current Permit No. :	Exp. Date:
(In State w	where presently located)
□ <u>Change of Ownership</u> → \$0	
Proposed date of Acquisition:	
Name of Previous Owner(s):	
(Confirmation statem	nent of previous must be attached)
	-→ \$0

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Date of Proposed Relocation:

Previous Address:

□ <u>Name Change</u> → \$0

Previous Name:

III. Ownership:

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

Subr

\ \

	Sole	Pro	prietor
--	------	-----	---------

- □ Partnership
- \Box LLC
- \Box Corporation
- \Box N/A

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

Name:	(O)	Title:		
Address (Ho	ome):			
СІТУ:	STATE:	COUNTY:	ZIP:	











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CITY:	STATE:	COUNTY:	ZIP:	
Phone Number(Home):			5
Phone Number(Business):		tion	
Date of Birth:			dicat	
Social Security	Number:	P	<u></u>	
Name:		Title:		
Address (Home):	S		
CITY:	STATE:	COUNTY:	ZIP:	
Address (Busine	ess):			
CITY:	STATE:	COUNTY:	ZIP:	
Phone Number(Home):			





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Social Security	Number:			<u>, , , , , , , , , , , , , , , , , , , </u>
Name:		Title:	Ó	
Address (Home):		ation	
CITY:	STATE:	COUNTY:	ZIP:	
Address (Busine	ess):	aitA		
CITY:	STATE:	COUNTY:	ZIP:	
Phone Number(Home):	<u> </u>		
Phone Number(Business)			
Date of Birth:	nce			
Social Security	Number:			
20				
Name:		Title:		

4









CITY:	STATE:	COUNTY:	ZIP:
Address (Busine	ess):		
CITY:	STATE:	COUNTY:	ZIP:
Phone Number(Home):		tion
Phone Number(Business):		dica
Date of Birth:		P	<i>5K</i>
Social Security	Number:	omit	
		CNP -	
Name:	4	Title:	
Address (Home)			
CITY:	STATE:	COUNTY:	ZIP:
Address (Busine	ess):		
CITY:	STATE:	COUNTY:	ZIP:
Phone Number(Home):		







Date of Birth:			
Social Security Number:	OU		
(Use supplem	nental information page if necessary)		
V. Pharmacist in Charge:	olicatio		
Name:	KY License No.:		
	2:205 requires the Pharmacist in charge to notify the Board within ar days of all pharmacist personnel changes.		
	culo:		
. Name and license/registr	ation number of pharmacy employees:		
Name:	License No. :		
Name:	License No. :		
Name:	License No. :		
Name:	License No. :		
Name	License No. :		
Name:	License No. :		

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











Name:	Title:	
		_ 0
Name:	Title:	jne
	0	
Name:	Title:	
Name:	Title:	
	R.	
Name:	Title:	
(U	se supplemental information page if necessary)	
	CUT	

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	<u>THURSDAY</u>	FRIDAY	<u>SATURDAY</u>	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

 \star Please indicate if closed for lunch:

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until

VIII. Discipline:











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

If yes: Please explain below X. Does the pharmacy ship any press commonwealth of Kentucky under a han the information of the pharmacy rovided with this application?	any name of return address other
commonwealth of Kentucky under a han the information of the pharmac	any name of return address other
commonwealth of Kentucky under a han the information of the pharmac	any name of return address other
commonwealth of Kentucky under a han the information of the pharmac	any name of return address other
□ YES*	
If yes: Please provide a list of the additional phar harmacy ships prescriptions to citizens of the Cor	
Referen	

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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:
	O ^N
	Cal.
	R
(Use supplemental information	page if necessary)
XI. Are you permitted in other states?	
□ YES*	
If yes: please list below	
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or Re	
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REQUIRED DOCUMENTATION MUST BE ENCLOSED

 \Box 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* M Control of the second second











Form 9/2023

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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:

	y of, 20
By:	
Signature:	
My Commission Expires Stat	e of
ature of Owner:	Date:
I hereby certify that the above Application for Non-Resident Spe	cial Limited Pharmacy Permit was
I hereby certify that the above Application for Non-Resident Spectrosection signed, subscribed and sworn to before me thisday	

TEAM TEAM







Form 9/2023

Date:

KENTUCKY BOARD OF PHARMACY State Office Building Annex, Suite 300 125 Holmes Street Frankfort KY 40601

NON-RESIDENT PHARMACY PERMIT VERIFICATION

ine

This form must be completed by the applicant and the Board of Pharmacy of the state in which the applicant is located, and returned with the non-resident pharmacy permit application to the Board office before a non-resident pharmacy permit will be issued.

Name of Pharmacy		All
Physical Address of Pharmacy	jic	
City	State	ZIP Code
Name of Pharmacist-in-Charge	License Numb	
The following section is to be completed by the Board of Pharmacy of the state	in which the app	licant is located:
Is the pharmacy properly licensed or registered in your state?	□ Yes	🗆 No
Has this pharmacy been the subject of disciplinary action(s) taken by any licen	sing jurisdiction.	government agency.
law enforcement agency or court?	□ Yes*	□ No
* If yes, attach a letter of explanation, a copy of the charging document/compl		
Has the Pharmacist-in-Charge been the subject of disciplinary action(s) taken	by any licensing ju	urisdiction, government
agency, law enforcement agency or court?	□ Yes*	🗆 No
*If yes, attach a letter of explanation, a copy of the charging document/compl	aint and all releva	ant court documents.
Printed name and title of State Official	State	
Signature of State Official	Date	
SEAL		



<u>,0</u>

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



Non-Resident Application for Special Limited Pharmacy Permit ⇒ Clinical Practice

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.

Name of Facil	ity:		
Physical Addr	ess of Facility:		
CITY:	STATE:	COUNTY:	ZIP:
Mailing Addre	ess of Facility:		
CITY:	STATE:	COUNTY:	ZIP:









Fax Number:	
Website Address:	0
Check and complete	one of the following and attach proper fee:
□ <u>New Facility</u> → \$150	D.00
Proposed date of Opening:	R66
(F	Filed with board 30 days in advance of opening)
<u>OR</u> Current Permit No. :	Exp. Date:
	(In State where presently located)
<u>Change of Ownersh</u> Dranaged data of A aquinitian:	
Proposed date of Acquisition:	
Name of Previous Owner(s):	
Please include detailed explanatio	on of the change, including type of transaction, date of transaction and structure of the transfer
Please include detailed explanation	structure of the transfer







Previous Address:

tine $\Box \underline{Name Change} \rightarrow NO CHARGE$ Previous Name: cation **III. Ownership:** How is the pharmacy registered with the Kentucky Secretary of State? SubmitA □ Sole Proprietor □ Partnership \Box LLC □ Corporation \Box N/A \star \star Name and title for each owner/officer/member, including professional designation (e.g. Pres. John Jones, PharmD):

Nan	ne:	Title:	
Nan	ne:	Title:	
Nan	ne:	Title:	
Nan	ne.	Title:	
Nan	ne:	Title:	
Nan	ne:	Title:	
	(Uas gunnlamon	tal information naga if nagagany)	

(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?

Name KY License No.:	Please explain below			0,
Name KY License No.:				
Name KY License No.:			Alle	
V. Pharmacist in Charge (P.I.C.), Pharmacist (s), Interns, and Technicians: Name KY License No.: P.I.C. : Comparison of the second				
Name KY License No.:			2	
Name KY License No.:	rmacist in Charge (PIC) P	harmacist(s	Interns and	
			, meerns, and	
	N		1/1/1· N	
	Name	\sim	KY License No.:	
Ce only		2		
		-		
(Use supplemental information page if necessary)			222222	
Kentucky Pharmacy Regulation 201 KAR 2:205 requires the Pharmacist in charge to notify the Board with fourteen (14) calendar days of all pharmacist personnel changes.				

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





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*Please indicate if closed for lunch: untiliio Supplemental Information Page.	*Please indicate if closed for lunch: untiliio Supplemental Information Page.	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	
supplemental Information Page.	supplemental Information Page.	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	
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nature of Pharmacist-in-Charge:	<u></u>	Date:
I hereby certify that the above Application for Pharma	cy Permit was signe	ed, subscribed and
sworn to before me thisday of	, 20	<u>-</u> -
By:		
Signature:		
My Commission Expires	State of	<u>.</u>
nature of Owner:	ON!	Date:
nature of Owner: I hereby certify that the above Application for Pharma	cy Permit was signe	
<u>101</u>		ed, subscribed and
I hereby certify that the above Application for Pharma		ed, subscribed and
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I hereby certify that the above Application for Pharma sworn to before me thisday of By:	, 20_	ed, subscribed and









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



Non-Resident Application for Special Limited Pharmacy Permit ⇒ Clinical Practice

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.

Name of Facil	ity:		
Physical Addr	ess of Facility:		
CITY:	STATE:	COUNTY:	ZIP:
Mailing Addre	ess of Facility:		
CITY:	STATE:	COUNTY:	ZIP:









Fax Number:	
Website Address:	0
Check and complete	one of the following and attach proper fee:
□ <u>New Facility</u> → \$150	D.00
Proposed date of Opening:	R66
(F	Filed with board 30 days in advance of opening)
<u>OR</u> Current Permit No. :	Exp. Date:
	(In State where presently located)
<u>Change of Ownersh</u> Dranaged data of A aquinitian:	
Proposed date of Acquisition:	
Name of Previous Owner(s):	
Please include detailed explanatio	on of the change, including type of transaction, date of transaction and structure of the transfer
Please include detailed explanation	structure of the transfer







Previous Address:

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Nan	ne:	Title:	
Nan	ne:	Title:	
Nan	ne:	Title:	
Nan	ne.	Title:	
Nan	ne:	Title:	
Nan	ne:	Title:	
	(Uas gunnlamon	tal information naga if nagagany)	

(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?

Name KY License No.:	Please explain below			0,
Name KY License No.:				
Name KY License No.:			Alle	
V. Pharmacist in Charge (P.I.C.), Pharmacist (s), Interns, and Technicians: Name KY License No.: P.I.C. : Comparison of the second				
Name KY License No.:			2	
Name KY License No.:	rmacist in Charge (PIC) P	harmacist(s	Interns and	
			, meerns, and	
	N		1/1/1· N	
	Name	\sim	KY License No.:	
Ce only		2		
		-		
(Use supplemental information page if necessary)			222222	
Kentucky Pharmacy Regulation 201 KAR 2:205 requires the Pharmacist in charge to notify the Board with fourteen (14) calendar days of all pharmacist personnel changes.				

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





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OPEN: OPEN: <t< th=""><th>CLOSE: CLOSE: CLOSE:</th><th><u>MONDAY</u></th><th><u>TUESDAY</u></th><th>WEDNESDAY</th><th>THURSDAY</th><th><u>FRIDAY</u></th><th><u>SATURDAY</u></th><th><u>SUNDAY</u></th><th></th></t<>	CLOSE: CLOSE:	<u>MONDAY</u>	<u>TUESDAY</u>	WEDNESDAY	THURSDAY	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>	
*Please indicate if closed for lunch: untiliio Supplemental Information Page.	*Please indicate if closed for lunch: untiliio Supplemental Information Page.	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	
supplemental Information Page.	supplemental Information Page.	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	
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Rei)							









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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.

nature of Pharmacist-in-Charge:	<u></u>	Date:
I hereby certify that the above Application for Pharma	cy Permit was signe	ed, subscribed and
sworn to before me thisday of	, 20	<u>-</u> -
By:		
Signature:		
My Commission Expires	State of	<u>.</u>
nature of Owner:	CN12	Date:
nature of Owner: I hereby certify that the above Application for Pharma	cy Permit was signe	
<u>101</u>		ed, subscribed and
I hereby certify that the above Application for Pharma		ed, subscribed and
I hereby certify that the above Application for Pharma		ed, subscribed and
I hereby certify that the above Application for Pharma sworn to before me thisday of By:	, 20_	ed, subscribed and









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 <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>. 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 Pharm	acy			
Kentucky Perm	it Number:			
Physical Addre	ss of Pharmacy:			
CITY:	STATE:	COUNTY:	ZIP:	
Email:				









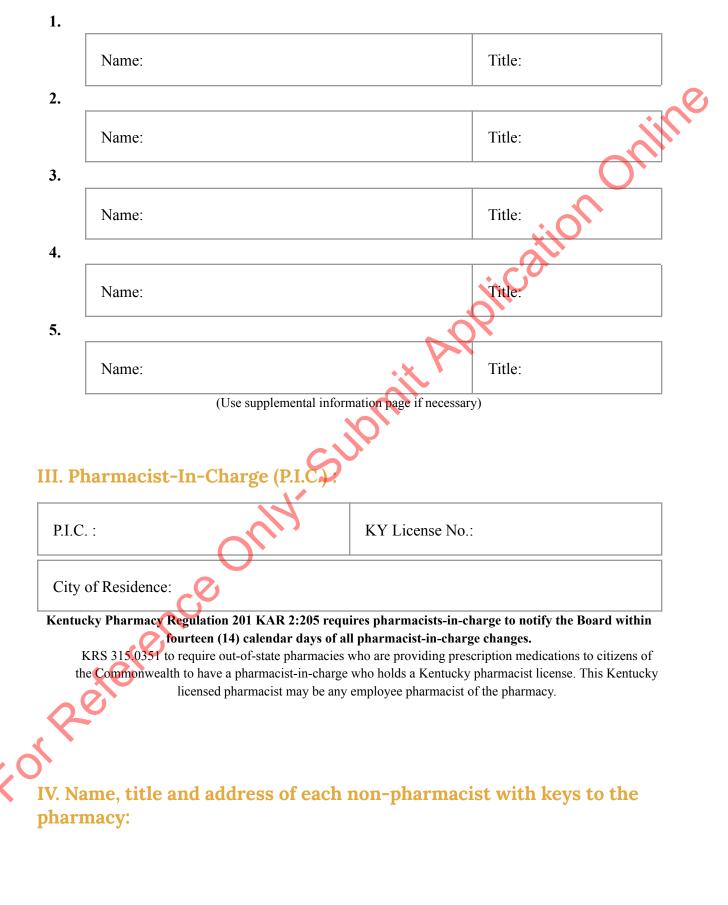
Phone number:	
Fax number:	
Toll Free Number:	OUM
Website Address:	70;
Date of last controlled substance inventory:	J.
Mailing Address of Pharmacy:	
CITY: STATE: COUNTY.	ZIP:
DEA Registration No.: Exp. Da	te:
II. Ownership: How are you registered with the Kentucky Secretary of Sole Proprietor Partnership LLC	'State?
 Corporation Not Applicable 	
★★ Name and title for each owner/officer/member, inclue professional designation:	ling office and

















Name:		Title:	
Address:			•
CITY:	STATE:	COUNTY:	ZIP:
Name:		Title:	tion
Address:			olice
CITY:	STATE:	COUNTY:	ZIP:
Name:		Title:	
Address:	14		
CITY:	STATE	COUNTY:	ZIP:
Name:		Title:	
Address:			
CITY:	STATE:	COUNTY:	ZIP:
Name:		Title:	









Address:				
CITY:	STATE:	COUNTY:	ZIP:	. ~
	(Use suppleme	ntal information page if necess	sary)	

V. Schedule of Hours:

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

MONDAY	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	FRIDAY	<u>SATURDAY</u>	<u>SUNDAY</u>
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. :
Ċ	Name:	License No. :
	Name:	License No. :
	Name:	License No. :









License No. :

(Use supplemental information page if necessary)

	🔲 Retail Chain	Infusion
Nuclear	🗌 Mail Order	Nursing Home
□ Internet*	Hospital	🗆 Central Fill
□ Compounding	□ Veterinary	Co
Commonwealth of Kentucky shipper]. If Internet is checked a /III. Does the pharmacy	, in whole or in part, via the I , digital pharmacy accreditation and Section 8 must be complete y dispense any prescription ucky that have been	riptions to citizens of the referred to the pharmacy
U YES*		









Address: CTY: STATE: CUTY: STATE: CUTY: COUNTY: Z.Name: Address: CUTY: STATE:						1
Email Address: Phone Number: 2. Name: Address: Address: CITY: STATE: CUTY: STATE: CUTY: <th></th> <th>Address:</th> <th></th> <th></th> <th></th> <th></th>		Address:				
Phone Number:		CITY:	STATE:	COUNTY:	ZIP:	
2.Name: Address: Address: CITY: STATE: COUNTY Image: County Phone Number: Online: Address:		Email Address:				
Address: CITY: STATE: COUNTY ZIP: Email Address: Phone Number: 3.Name: Address:		Phone Number:				
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		3.Name:				
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Email Address:	< C	Email Address:				









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Address:	ally			
лту:	STATE:	COUNTY:	ZIP:	
Email Address:	-			

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:
	0,,,,
	2.Name:
	Business Address:
R	CITY: STATE: COUNTY: ZIP:
401	Business Phone:
•	Email Address:









	DEA Number:	State(s) of licensure:		
	Social Security Number: (optional)	Date of Birth:		
		OUH.		
	3. Name:	70;;		
	Business Address:	i cati		
	CITY: STATE: COU	UNTY: ZIP:		
	Business Phone:			
	Email Address:			
	DEA Number:	State(s) of licensure:		
	Social Security Number: (optional)	Date of Birth:		
	ance			
	4.Name:			
.8	Business Address:			
<i>40</i>	CITY: STATE: COU	JNTY: ZIP:		
	Business Phone:			









DEA Number:	State(s) of licensure:
Social Security Number: (optional)	Date of Birth:
5.Name:	icali
Business Address:	<u>0</u> 91
CITY: STATE: C	COUNTY: ZIP:
Business Phone:	Jou.
Email Address:	
DEA Number:	State(s) of licensure:
Social Security Number: (optional)	Date of Birth:
(Use supplemental info	ormation page if necessary)

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











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*If yes: Please list below

IV. Have vou had a Pharmacy lic	
· · · · · · · · · · · · · · · · · · ·	cense/permit disciplined by any en disciplined by any other agency ported to this Board?
□ YES*	O NO
f yes: Please explain below	·* P.9 *
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C	2
V. List the names and resident s harmacist performing any funct atient:	state license numbers of any staff tion on a prescription for a KY
Name:	License No. :
Name:	License No. :
Jame	License No. :
Name:	License No. :
Name:	License No. :

(Use supplemental information page if necessary)



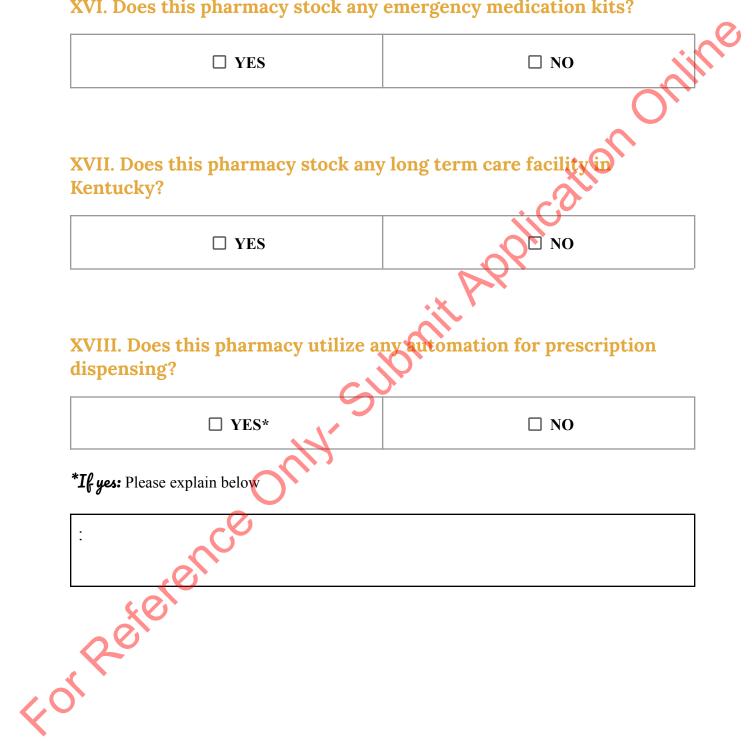
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XVI. Does this pharmacy stock any emergency medication kits?











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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:

I hereby certify that the above Renewal Application for Non-Resident Pharmacy Permit was

signed, subscribed and sworn to before me this _

By:

Signature:

My Commission Expires

Signature of Owner:

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____.

Signature:

My Commission Expires State of .

State of









Date:

Date:

day of ______, 20_____.

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 <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>. 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 Pharm	acy			
Kentucky Perm	it Number:			
Physical Addre	ss of Pharmacy:			
CITY:	STATE:	COUNTY:	ZIP:	
Email:				









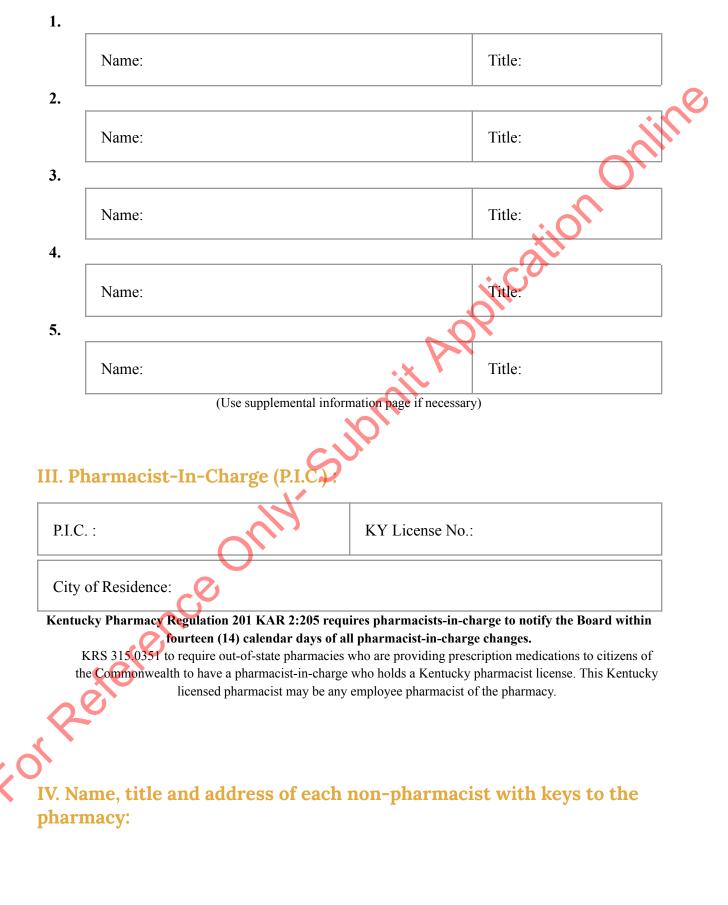
Phone number:	
Fax number:	
Toll Free Number:	OUM
Website Address:	70;
Date of last controlled substance inventory:	J.
Mailing Address of Pharmacy:	
CITY: STATE: COUNTY.	ZIP:
DEA Registration No.: Exp. Da	te:
II. Ownership: How are you registered with the Kentucky Secretary of Sole Proprietor Partnership LLC	'State?
 Corporation Not Applicable 	
★★ Name and title for each owner/officer/member, inclue professional designation:	ling office and











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









Address:				
CITY:	STATE:	COUNTY:	ZIP:	. ~
	(Use suppleme	ntal information page if necess	sary)	

V. Schedule of Hours:

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

MONDAY	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	FRIDAY	<u>SATURDAY</u>	<u>SUNDAY</u>
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. :
Ċ	Name:	License No. :
	Name:	License No. :
	Name:	License No. :









License No. :

(Use supplemental information page if necessary)

	🔲 Retail Chain	Infusion
Nuclear	🗌 Mail Order	Nursing Home
□ Internet*	Hospital	🗆 Central Fill
□ Compounding	□ Veterinary	Co
Commonwealth of Kentucky shipper]. If Internet is checked a /III. Does the pharmacy	, in whole or in part, via the I , digital pharmacy accreditation and Section 8 must be complete y dispense any prescription ucky that have been	riptions to citizens of the referred to the pharmacy
U YES*		









Address: CTY: STATE: CUTY: STATE: CUTY: COUNTY: Z.Name: Address: CUTY: STATE:						1
Email Address: Phone Number: 2. Name: Address: Address: CITY: STATE: CUTY: STATE: CUTY: <th></th> <th>Address:</th> <th></th> <th></th> <th></th> <th></th>		Address:				
Phone Number:		CITY:	STATE:	COUNTY:	ZIP:	
2.Name: Address: Address: CITY: STATE: COUNTY Image: County Phone Number: Online: Address:		Email Address:				
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Address: CITY: STATE: COUNTY ZIP: Email Address: Phone Number: 3.Name: Address:					alle	_
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Phone Number:

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Email Address:	-			

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:
	0,,,,
	2.Name:
	Business Address:
R	CITY: STATE: COUNTY: ZIP:
401	Business Phone:
•	Email Address:









	DEA Number:	State(s) of licensure:
	DEA Number.	
	Social Security Number: (optional)	Date of Birth:
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	3. Name:	70;;
	Business Address:	i cati
	CITY: STATE: COU	UNTY: ZIP:
	Business Phone:	
	Email Address:	
	DEA Number:	State(s) of licensure:
	Social Security Number: (optional)	Date of Birth:
	ance	
	4.Name:	
.8	Business Address:	
<i>40</i>	CITY: STATE: COU	JNTY: ZIP:
	Business Phone:	









DEA Number:	State(s) of licensure:
Social Security Number: (optional)	Date of Birth:
5.Name:	icali
Business Address:	<u>0</u> 91
CITY: STATE: C	COUNTY: ZIP:
Business Phone:	Jou.
Email Address:	
DEA Number:	State(s) of licensure:
Social Security Number: (optional)	Date of Birth:
(Use supplemental info	ormation page if necessary)

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











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*If yes: Please list below

IV. Have vou had a Pharmacy lic	
· · · · · · · · · · · · · · · · · · ·	cense/permit disciplined by any en disciplined by any other agency ported to this Board?
□ YES*	O NO
f yes: Please explain below	·* P.9 *
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V. List the names and resident s harmacist performing any funct atient:	state license numbers of any staff tion on a prescription for a KY
Name:	License No. :
Name:	License No. :
Jame	License No. :
Name:	License No. :
Name:	License No. :

(Use supplemental information page if necessary)



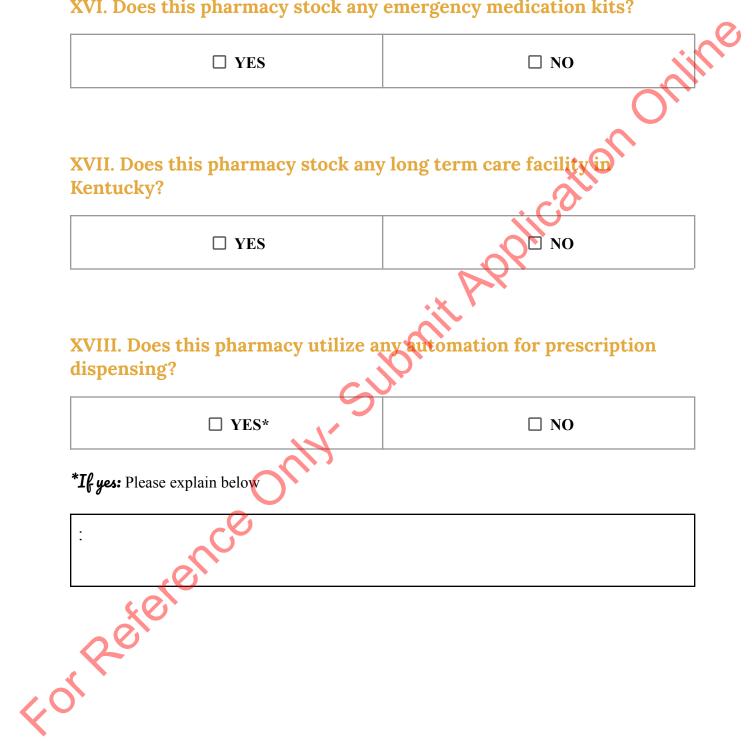
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XVI. Does this pharmacy stock any emergency medication kits?











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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:

I hereby certify that the above Renewal Application for Non-Resident Pharmacy Permit was

signed, subscribed and sworn to before me this _

By:

Signature:

My Commission Expires

Signature of Owner:

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____.

Signature:

My Commission Expires State of .

State of









Date:

Date:

day of ______, 20_____.

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 Pharm	hacy			
Kentucky Perm	it Number:			
Address:				
CITY:	STATE:	COUNTY:	ZIP:	
Email Address:				











Fax Number:	* .
Website Address:	On
Date of last controlled substance inventory:	no _i .
DEA Registration No.:	Exp. Date:
	DQV.
. Ownership:	
ow are you registered with the K	Kentucky Secretary of State?
□ Sole Proprietor	Kentucky Secretary of State?
 Sole Proprietor Partnership 	Kentucky Secretary of State?
 Sole Proprietor Partnership Corporation 	Kentucky Secretary of State?
 Sole Proprietor Partnership Corporation LLC 	Kentucky Secretary of State?
 Sole Proprietor Partnership Corporation LLC Other 	
 Sole Proprietor Partnership Corporation LLC Other ★ * Name and title for each owned 	er/officer/member, including office and
 Partnership Corporation LLC Other ★ ★ Name and title for each owned 	
 Sole Proprietor Partnership Corporation LLC Other ★ * Name and title for each owner professional 	er/officer/member, including office and











	Name:	Title:	
4.			
	Name:	Title:	~©
5.			•
	Name:	Title:	
	(Use supplemental information page if necessar	y)	
III. So	chedule of Hours:	olicali	

III. Schedule of Hours:

(P.I.C. must notify the Board within fourteen	(14) days of any cl	hanges in scheduled hours.)
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<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
24 HOURS	☐ 24 HOURS	L 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS

 \star Please indicate if closed for lunch:

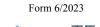












*This must be checked if the pharmacy dispenses any prescriptions to citizens of the Commonwealth of Kentucky, in whole or in part, via the Internet [agent, internet broker or shipper]. If Internet is checked, digital pharmacy accreditation will be verified with the NABP.

□ YES	
. Do you perform sterile compounding	s? dicatio.
□ YES	
□ YES	□ NO
III. Are you permit ed in other states?	
GIYES	
YES	
If yes: Please list below	



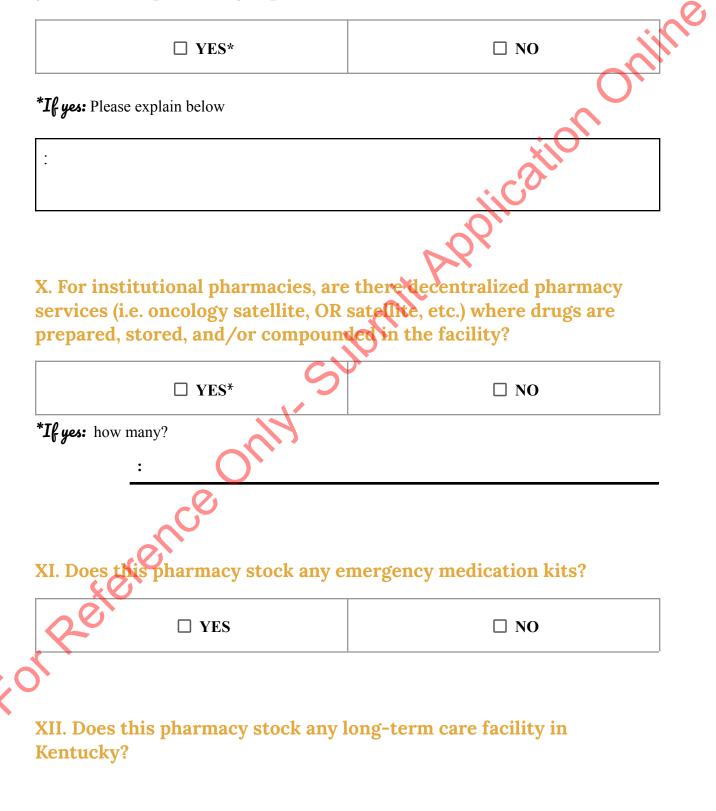








IX. Have you had a Pharmacy license/permit disciplined by any other agency or has your PIC been disciplined by any other agency which you have not previously reported to this Board?







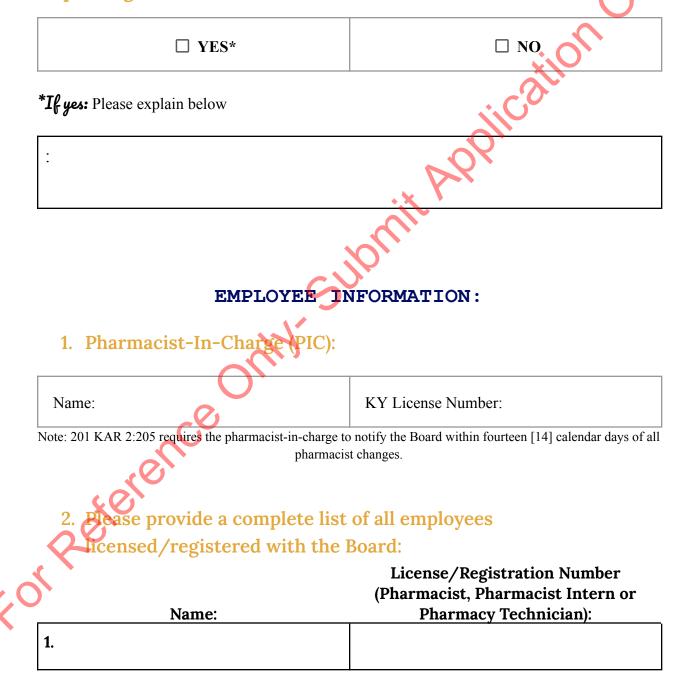






□ YES	
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XIII. Does this pharmacy utilize any automation for prescription dispensing?





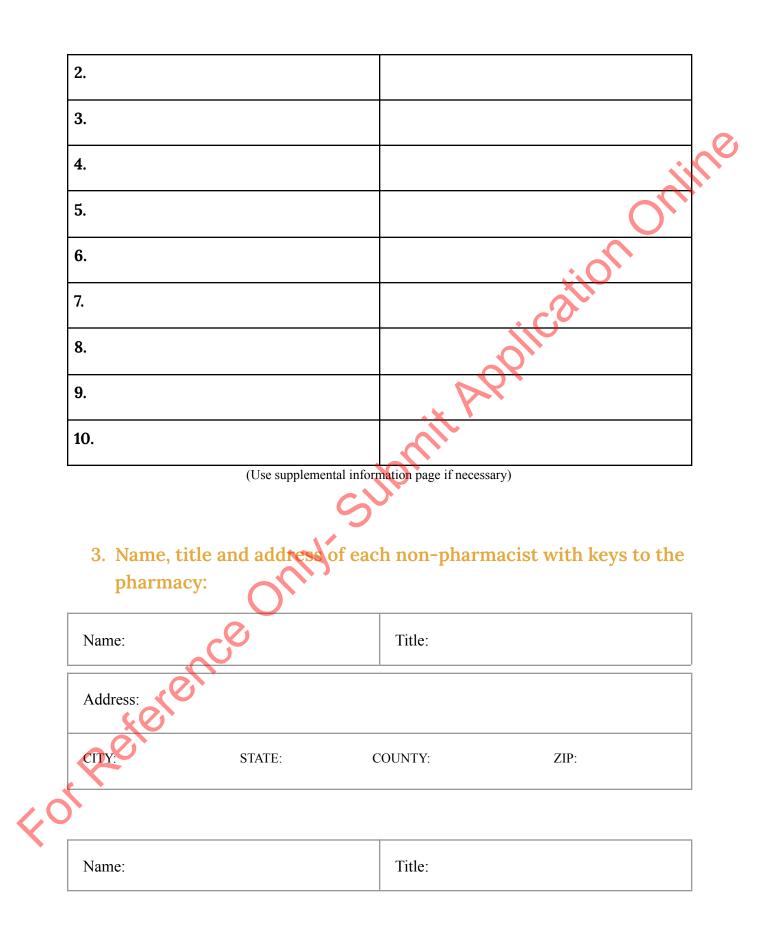








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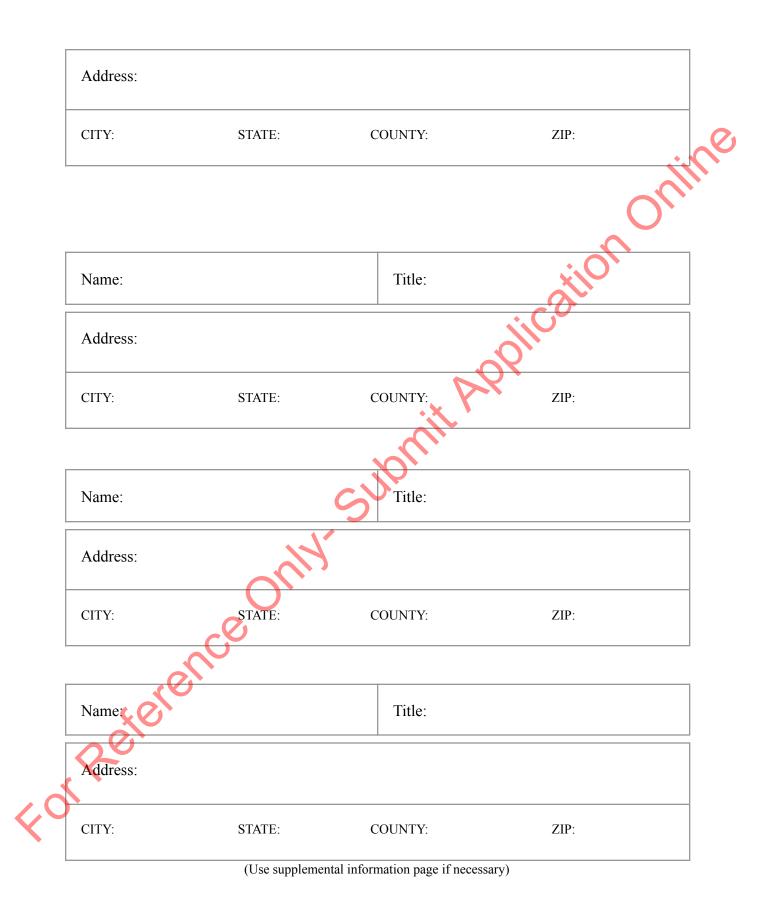




















4. Please submit the name, address and affiliation of all individuals, other than those previously identified in this application, responsible for pharmacy operations, management or staffing (eg. Pharmacy Services Management companies or consultants)

Name:		Affiliation:		0,,
Address:			il	
CITY:	STATE:	COUNTY:	ZIP:	
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Address:	Ç	jul		
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Address:				
CITY:	STATE:	COUNTY:	ZIP:	
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Name:		Affiliation:		











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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.

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 _

Signature of Pharmacist-in-Charge:

Date:

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____.

Signature:

My Commission Expires _____ State of _____.









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 Pharm	hacy			
Kentucky Perm	it Number:			
Address:				
CITY:	STATE:	COUNTY:	ZIP:	
Email Address:				











Fax Number:	<b>*</b> .
Website Address:	On
Date of last controlled substance inventory:	no _i .
DEA Registration No.:	Exp. Date:
	DQV.
. Ownership:	
ow are you registered with the K	Kentucky Secretary of State?
□ Sole Proprietor	Kentucky Secretary of State?
<ul> <li>Sole Proprietor</li> <li>Partnership</li> </ul>	Kentucky Secretary of State?
<ul> <li>Sole Proprietor</li> <li>Partnership</li> <li>Corporation</li> </ul>	Kentucky Secretary of State?
<ul> <li>Sole Proprietor</li> <li>Partnership</li> <li>Corporation</li> <li>LLC</li> </ul>	Kentucky Secretary of State?
<ul> <li>Sole Proprietor</li> <li>Partnership</li> <li>Corporation</li> <li>LLC</li> <li>Other</li> </ul>	
<ul> <li>Sole Proprietor</li> <li>Partnership</li> <li>Corporation</li> <li>LLC</li> <li>Other</li> <li>★ * Name and title for each owned</li> </ul>	er/officer/member, including office and
<ul> <li>Partnership</li> <li>Corporation</li> <li>LLC</li> <li>Other</li> <li>★ ★ Name and title for each owned</li> </ul>	
<ul> <li>Sole Proprietor</li> <li>Partnership</li> <li>Corporation</li> <li>LLC</li> <li>Other</li> <li>★ * Name and title for each owner professional</li> </ul>	er/officer/member, including office and











	Name:	Title:	
4.			
	Name:	Title:	~®
5.			•
	Name:	Title:	
	(Use supplemental information page if necessar	y)	
III. So	chedule of Hours:	olicali	

#### **III. Schedule of Hours:**

(P.I.C. must notify the Board within fourteen	(14) days of any cl	hanges in scheduled hours.)
-----------------------------------------------	---------------------	-----------------------------

<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	THURSDAY	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
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 $\star$  Please indicate if closed for lunch:

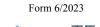












*This must be checked if the pharmacy dispenses any prescriptions to citizens of the Commonwealth of Kentucky, in whole or in part, via the Internet [agent, internet broker or shipper]. If Internet is checked, digital pharmacy accreditation will be verified with the NABP.

□ YES	
. Do you perform sterile compounding	s? dicatio.
□ YES	
□ YES	□ NO
III. Are you permit ed in other states?	
<b>Ú</b> YES	
<b>If yes:</b> Please list below	



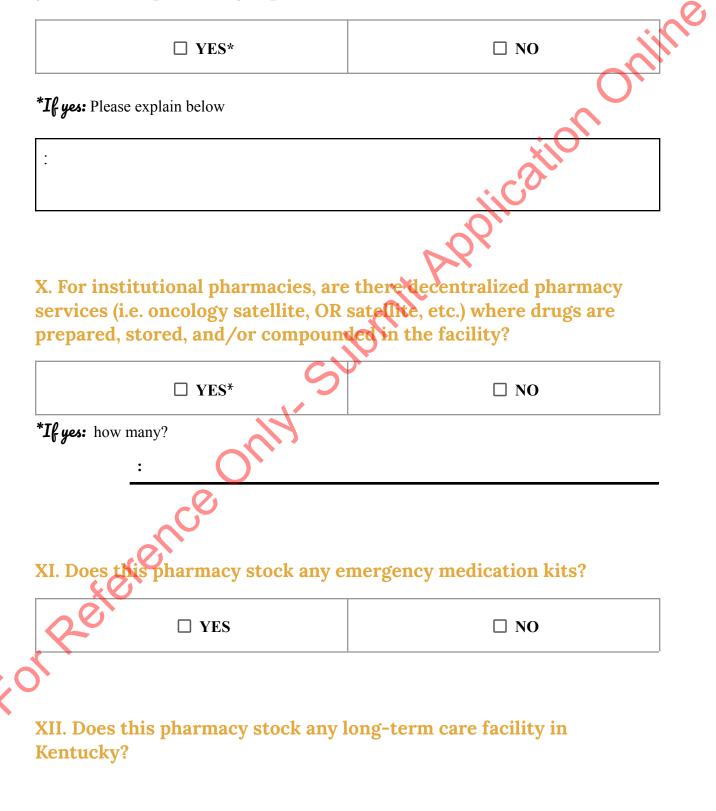








IX. Have you had a Pharmacy license/permit disciplined by any other agency or has your PIC been disciplined by any other agency which you have not previously reported to this Board?







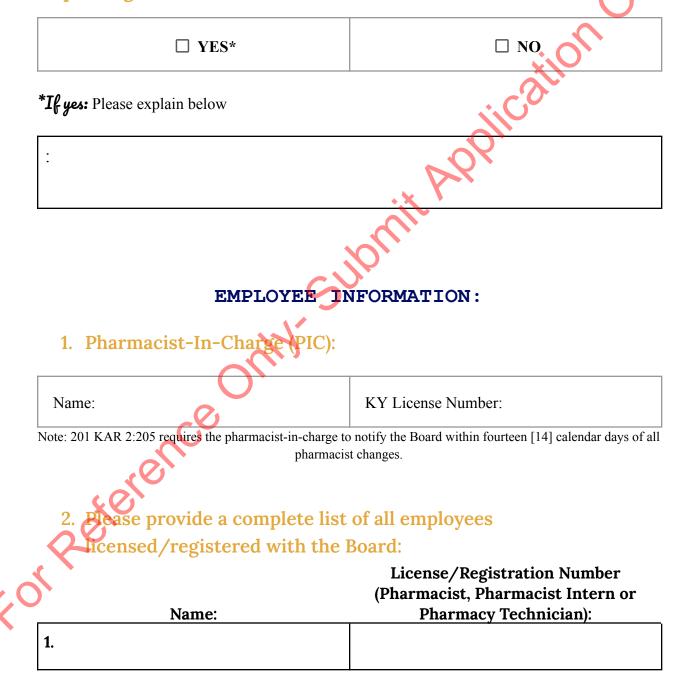






□ YES	
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## XIII. Does this pharmacy utilize any automation for prescription dispensing?





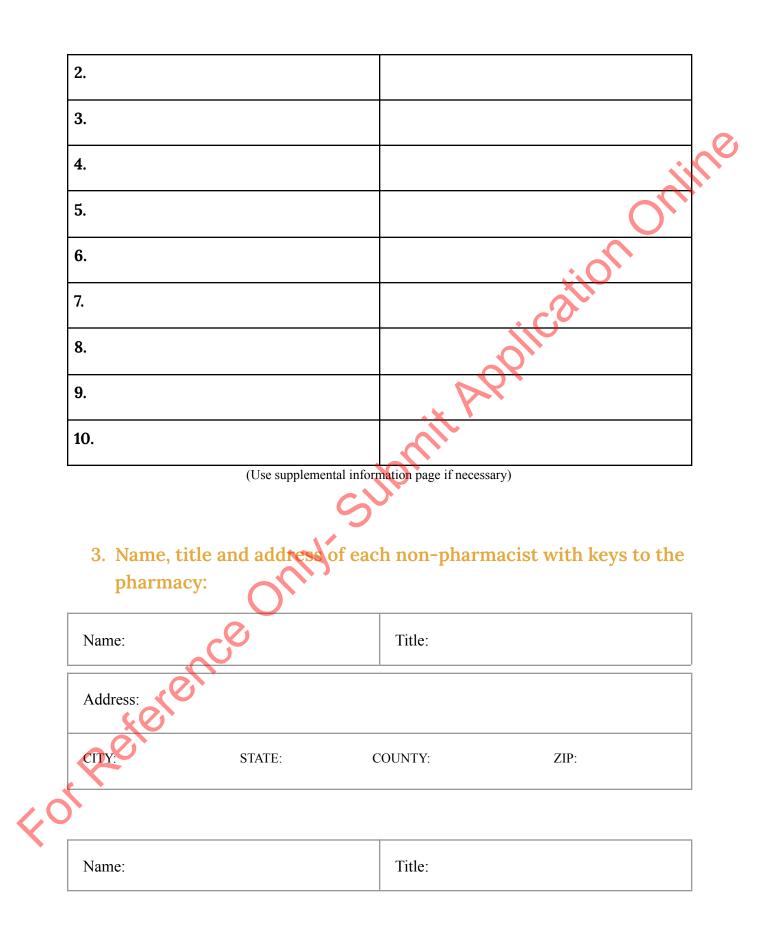








TIME



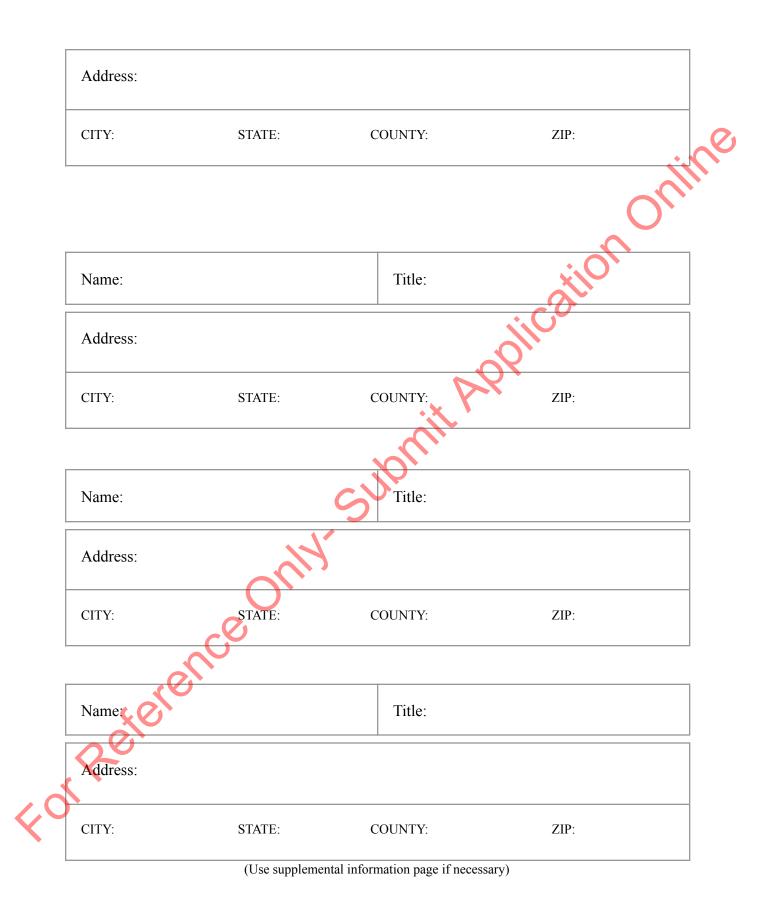




















4. Please submit the name, address and affiliation of all individuals, other than those previously identified in this application, responsible for pharmacy operations, management or staffing (eg. Pharmacy Services Management companies or consultants)

Name:		Affiliation:		0,,
Address:			il	
CITY:	STATE:	COUNTY:	ZIP:	
		<u> </u>	<u> </u>	
Name:		Affiliation:		
Address:	Ç	jul		
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Name:		Affiliation:		











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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.

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 _

Signature of Pharmacist-in-Charge:

Date:

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____.

Signature:

My Commission Expires _____ State of _____.









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 Special Limited Pharmacy Permit

⇒ Clinical Practice 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).

I. Facility Information:

	Name of Facility:	OUHY			
	Kentucky Permit No.:	3			
	Physical Address of Fac	cility:			
	CITY:	STATE:	COUNTY:	ZIP:	
02	Email Address:				











Fax Number:	
Website Address:	\circ
I. Ownership:	XIO
	ad with the Ventueland Advance of State?
low is the pharmacy register	ed with the Kentucky Secretary of State?
□ Sole Proprietor	
□ Partnership	
\Box LLC	
□ Corporation	
□ Other	
	ch owner/officer/member, including
professional designation	on (e.g. Pres. John Jones, PharmD):
Name:	Title:
	m: 1
Name.	Title:

TEAM **KENTUCKY** TEAM KENTÜCKY









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

□ YES*	
yes: Please explain below	
	catlor.
Pharmacist in Charge (P.I.C.), F chnicians:	Pharmacist(s), Interns and
Name	KY License No.:
I.C. :	
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V. Schedule of Hours: (P.I.C. must notify the Board within fourteen (14) days of any changes in scheduled hours.)













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MONDAY	<u>TUESDAY</u>	<u>WEDNESDAY</u>	THURSDAY	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>	
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	
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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.

nature of Pharmacist-in-Charge:	Date:
I hereby certify that the above Renewal Application for P	Pharmacy Permit was signed, subscribe
and sworn to before me thisday of	of, 20
By:	
Signature:	CALL SA
Signiture.	
My Commission Expires	_State of
nature of Owner:	Date:
nature of Owner:	Date:
nature of Owner: I hereby certify that the above Renewal Application for P	
I hereby certify that the above Renewal Application for P	harmacy Permit was signed, subscribe
	harmacy Permit was signed, subscribe
I hereby certify that the above Renewal Application for P and sworn to before me thisday of	harmacy Permit was signed, subscribe
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I hereby certify that the above Renewal Application for P and sworn to before me thisday of	harmacy Permit was signed, subscribe
I hereby certify that the above Renewal Application for P and sworn to before me thisday or By: Signature:	Pharmacy Permit was signed, subscribe
I hereby certify that the above Renewal Application for P and sworn to before me thisday of By:	Pharmacy Permit was signed, subscribe
I hereby certify that the above Renewal Application for P and sworn to before me thisday or By: Signature:	Pharmacy Permit was signed, subscribe







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 Special Limited Pharmacy Permit

⇒ Clinical Practice 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).

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	Name of Facility:	OUHY			
	Kentucky Permit No.:	3			
	Physical Address of Fac	cility:			
	CITY:	STATE:	COUNTY:	ZIP:	
02	Email Address:				











Fax Number:	
Website Address:	\circ
I. Ownership:	XIO
	ad with the Ventueland Advance of State?
low is the pharmacy register	ed with the Kentucky Secretary of State?
□ Sole Proprietor	
□ Partnership	
\Box LLC	
□ Corporation	
□ Other	
	ch owner/officer/member, including
professional designation	on (e.g. Pres. John Jones, PharmD):
Name:	Title:
	m: 1
Name.	Title:

TEAM **KENTUCKY** TEAM KENTÜCKY









KENT

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□ YES*	
yes: Please explain below	
	catlor.
Pharmacist in Charge (P.I.C.), F chnicians:	Pharmacist(s), Interns and
Name	KY License No.:
I.C. :	
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V. Schedule of Hours: (P.I.C. must notify the Board within fourteen (14) days of any changes in scheduled hours.)













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MONDAY	<u>TUESDAY</u>	<u>WEDNESDAY</u>	THURSDAY	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>	
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	
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nature of Pharmacist-in-Charge:	Date:
I hereby certify that the above Renewal Application for P	Pharmacy Permit was signed, subscribe
and sworn to before me thisday of	of, 20
By:	
Signature:	CALL SA
Signiture.	
My Commission Expires	_State of
nature of Owner:	Date:
nature of Owner:	Date:
nature of Owner: I hereby certify that the above Renewal Application for P	
I hereby certify that the above Renewal Application for P	harmacy Permit was signed, subscribe
	harmacy Permit was signed, subscribe
I hereby certify that the above Renewal Application for P and sworn to before me thisday of	harmacy Permit was signed, subscribe
I hereby certify that the above Renewal Application for P	harmacy Permit was signed, subscribe
I hereby certify that the above Renewal Application for P and sworn to before me thisday of	harmacy Permit was signed, subscribe
I hereby certify that the above Renewal Application for P and sworn to before me thisday or By: Signature:	Pharmacy Permit was signed, subscribe
I hereby certify that the above Renewal Application for P and sworn to before me thisday of By:	Pharmacy Permit was signed, subscribe
I hereby certify that the above Renewal Application for P and sworn to before me thisday or By: Signature:	Pharmacy Permit was signed, subscribe







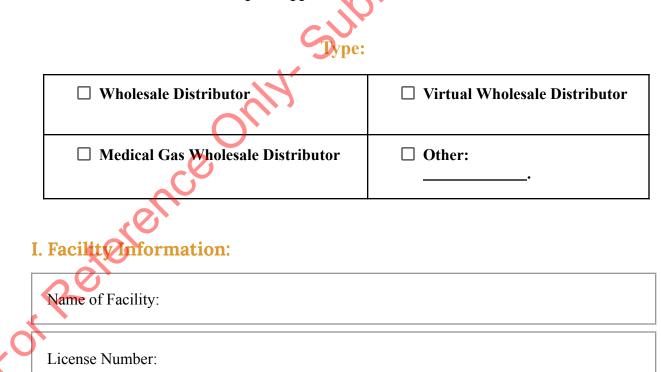
KENTUCKY BOARD OF PHARMACY State Office Building Annex,Suite 300 125 Holmes Street Frankfort KY 40601 Phone:(502) 564-7910 Fax:(502) 696-3806 Email: pharmacy.board@ky.gov http://pharmacy.ky.gov



Renewal Application to Operate as a Wholesaler

All permits expire September 30 and are not transferable. Please print legibly and submit each application with a check or money order in the amount of \$150.00 made payable to the "KENTUCKY STATE TREASURER". Mail to the above address. Payment can also be made online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal.

Incomplete applications will be returned.



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CITY:	STATE:	COUNTY:	ZIP:	•
Email:				Or
Phone number:				
Fax number:			icati	
DEA Registration No.	.:	7	Exp. Date:	
II. Name, title, pho	one and em	ail of the facility	contact person:	
II. Name, title, pho	one and em	ail of the facility	contact person:	
II. Name, title, pho Name:	one and em	ail of the facility	contact person:	
	one and em	ail of the facility	contact person:	
Name:	one and em	ail of the facility	contact person:	
Name: Title:	one and em	ail of the facility	contact person:	
Name: Title: Phone number:	one and em	ail of the facility	contact person:	
Name: Title: Phone number:	one and em	ail of the facility	contact person:	
Name: Title: Phone number: Email:	e on the			

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- □ Partnership
- \Box LLC
- \Box Corporation
- \Box Other

ine ★ ★ Pursuant to 201 KAR 2:105, Section 4, please provide the following information for each owner/officer/member, including professional designation (e.g. Pres. John Jones, M.D.):

1.	alle
Name:	Title:
Phone number(Business):	it
Phone number(Home):	lon.
Social Security Number:	Date of Birth:
Address(Home):	
CITY: STATE:	COUNTY: ZIP:
Address(Business):	
CTTY: STATE:	COUNTY: ZIP:
2.	
Name:	Title:









Phone number(H	lome):		
Social Security N	Number:	Date of Birth:	0
Address(Home):			101
CITY:	STATE:	COUNTY:	ZIP:
Address(Busines	s):	, pr	%
CITY:	STATE:	COUNTY:	ZIP:
•		SUP	
Name:	14	Title:	
Phone number(B	usiness):		
Phone number(H	ome):		
Social Security N	Number:	Date of Birth:	
Address(Home):			
CITY:	STATE:	COUNTY:	ZIP:

KENTUCKY KENTUCKY







CITY:	STATE:	COUNTY:	ZIP:
			00
Name:		Title:	
Phone number(E	Business):		Calle
Phone number(H	Iome):	2	2911
Social Security 1	Number:	Date of Birth:	
Address(Home):		SUDI	
CITY:	STATE:	COUNTY:	ZIP:
Address(Busines	ss):		
CITY:	STATE:	COUNTY:	ZIP:
eter -			
Name:		Title:	

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Phone number(F	Iome):		
Social Security 1	Number:	Date of Birth:	
Address(Home):	:		OUM
CITY:	STATE:	COUNTY:	ZIP:
Address(Busines	ss):		licat
CITY:	STATE:	COUNTY:	ZIP:
	(Use supplement	ntal information page if necessary)	
IV. Qualifying	Questions:	cupm	

IV. Qualifying Questions:

1. Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever been convicted of any felony under federal, state, and/or local laws not previously reported to the Board?

□ YES*	
*If yes: please provide explanation below:	
Explanation:	

2. Has applicant, or any owner[s], partner[s], officer[s], agent or employee of the applicant, ever had a license or permit related to drugs revoked or suspended by any federal, state, or local government not previously reported to the Board?



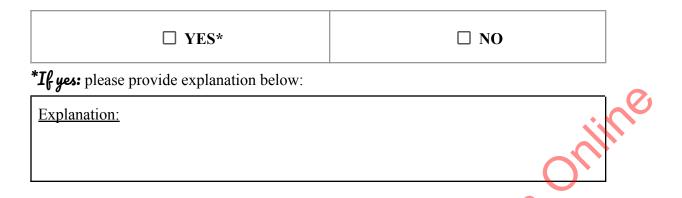












3. Has applicant, or any owner[s], partner[s], officer[s], agent or employee of the applicant, ever been convicted under federal, state and/or local drug laws, including drug samples and wholesale or retail drug distribution of controlled substances not previously reported to the Board?

□ YES*	
*If yes: please provide explanation below:	
Explanation:	
allo allo	

V. Schedule of Hours:

MONDAY	TUESDAY	WEDNESDAY	<u>THURSDAY</u>	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

VI. Does this facility have a Digital Distributor Accreditation?

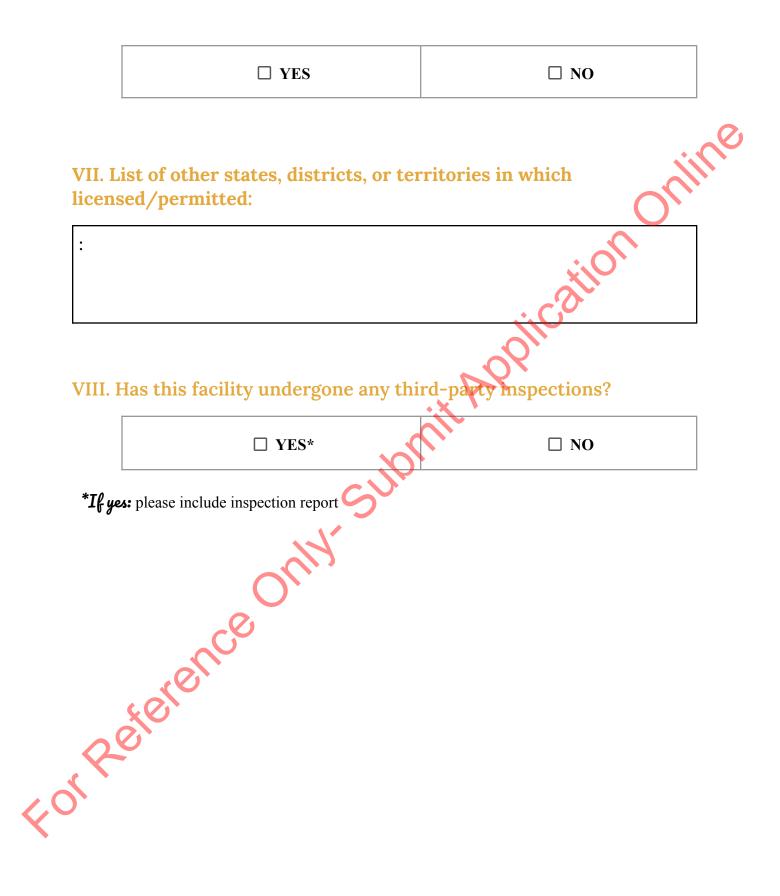












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The Board may refuse to issue or renew a license/permit or suspend, temporarily suspend, revoke, fine or reasonably restrict the license/permit holder for knowingly making or causing to be made any false, fraudulent or forged statement in connection with an application for a permit. See KRS 315.121.

I hereby certify that the foregoing is true and correct to the best of my knowledge. If the registration herein applied for is granted, I certify that this business will be conducted in full compliance with all applicable federal and state laws and that I will make available any or all records required by law to the extent authorized by law.

Signature and Title of Owner/ Manager:

I hereby certify that the above Renewal Application for Wholesaler was signed, subscribed and

sworn to before me this ______ day of ______, 20_____

By:

Signature:

My Commission Expires _____ State of

Changes in the above information must be submitted in writing with the appropriate application fee to the Board office within thirty (30) days.

**KENTUCKY** 











Form 6/2023

Date:

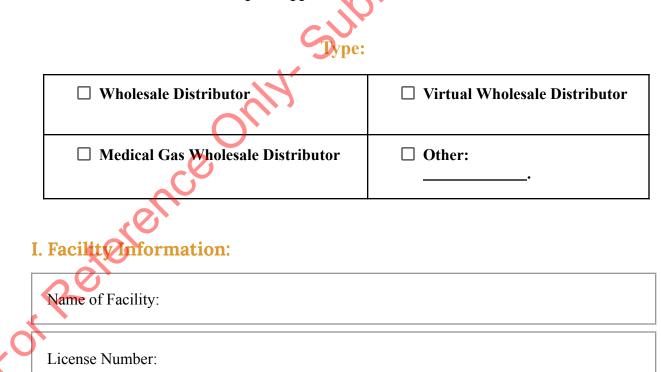
KENTUCKY BOARD OF PHARMACY State Office Building Annex,Suite 300 125 Holmes Street Frankfort KY 40601 Phone:(502) 564-7910 Fax:(502) 696-3806 Email: pharmacy.board@ky.gov http://pharmacy.ky.gov



## Renewal Application to Operate as a Wholesaler

All permits expire September 30 and are not transferable. Please print legibly and submit each application with a check or money order in the amount of \$150.00 made payable to the "KENTUCKY STATE TREASURER". Mail to the above address. Payment can also be made online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal.

#### Incomplete applications will be returned.



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CITY:	STATE:	COUNTY:	ZIP:	•
Email:				20
Phone number:			noix	
Fax number:			licat	
DEA Registration No.	:	7	Exp. Date:	
II. Name, title, pho	one and em	ail of the facility	contact person:	
II. Name, title, pho	one and em	ail of the facility	contact person:	
II. Name, title, pho Name:	one and em	ail of the facility	contact person:	
	one and em	ail of the facility	contact person:	
Name:	one and em	ail of the facility	v contact person:	
Name: Title:	one and em	ail of the facility	v contact person:	
Name: Title: Phone number:	one and em	ail of the facility	v contact person:	
Name: Title: Phone number:	one and em	ail of the facility	v contact person:	
Name: Title: Phone number: Email:	e on the second			

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- □ Partnership
- $\Box$  LLC
- $\Box$  Corporation
- $\Box$  Other

### ine ★ ★ Pursuant to 201 KAR 2:105, Section 4, please provide the following information for each owner/officer/member, including professional designation (e.g. Pres. John Jones, M.D.):

1.	alle
Name:	Title:
Phone number(Business):	it
Phone number(Home):	
Social Security Number:	Date of Birth:
Address(Home):	
CITY: STATE:	COUNTY: ZIP:
Address(Business):	
CTTY: STATE:	COUNTY: ZIP:
2.	
Name:	Title:









Phone number(H	Iome):		
Social Security N	Number:	Date of Birth:	0
Address(Home):			70,
CITY:	STATE:	COUNTY:	ZIP:
Address(Busines	ss):	, pr	<i>8</i> ,
CITY:	STATE:	COUNTY:	ZIP:
•		SUP	
Name:	14	Title:	
Phone number(E	Business):		
Phone number(F	lome):		
Social Security 1	Number:	Date of Birth:	
Address(Home):			
CITY:	STATE:	COUNTY:	ZIP:

KENTUCKY KENTUCKY







CITY:	STATE:	COUNTY:	ZIP:
			Or
Name:		Title:	
Phone number(E	Business):		Calle
Phone number(H	Iome):	2	² P ^{tt}
Social Security 1	Number:	Date of Birth:	
Address(Home):		SUDI	
CITY:	STATE:	COUNTY:	ZIP:
Address(Busines	ss):		
CITY:	STATE:	COUNTY:	ZIP:
eter -			
Name:		Title:	

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Phone number(H	Iome):		
Social Security	Number:	Date of Birth:	
Address(Home)	:		OUM
CITY:	STATE:	COUNTY:	ZIP:
Address(Busines	ss):		licat
CITY:	STATE:	COUNTY:	ZIP:
	(Use supplement	ntal information page if necessary)	
IV. Qualifying	Questions:	cupm	

#### **IV. Qualifying Questions:**

1. Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever been convicted of any felony under federal, state, and/or local laws not previously reported to the Board?

□ YES*	
*If yes: please provide explanation below:	
Explanation:	

2. Has applicant, or any owner[s], partner[s], officer[s], agent or employee of the applicant, ever had a license or permit related to drugs revoked or suspended by any federal, state, or local government not previously reported to the Board?



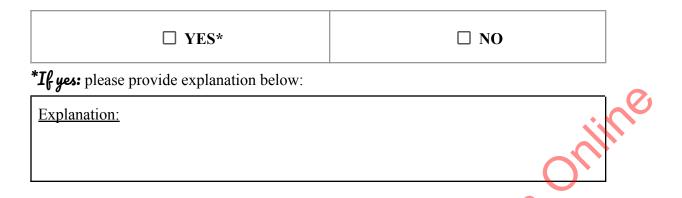












3. Has applicant, or any owner[s], partner[s], officer[s], agent or employee of the applicant, ever been convicted under federal, state and/or local drug laws, including drug samples and wholesale or retail drug distribution of controlled substances not previously reported to the Board?

□ YES*	
*If yes: please provide explanation below:	
Explanation:	
allo allo	

V. Schedule of Hours:

MONDAY	TUESDAY	WEDNESDAY	<u>THURSDAY</u>	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

VI. Does this facility have a Digital Distributor Accreditation?

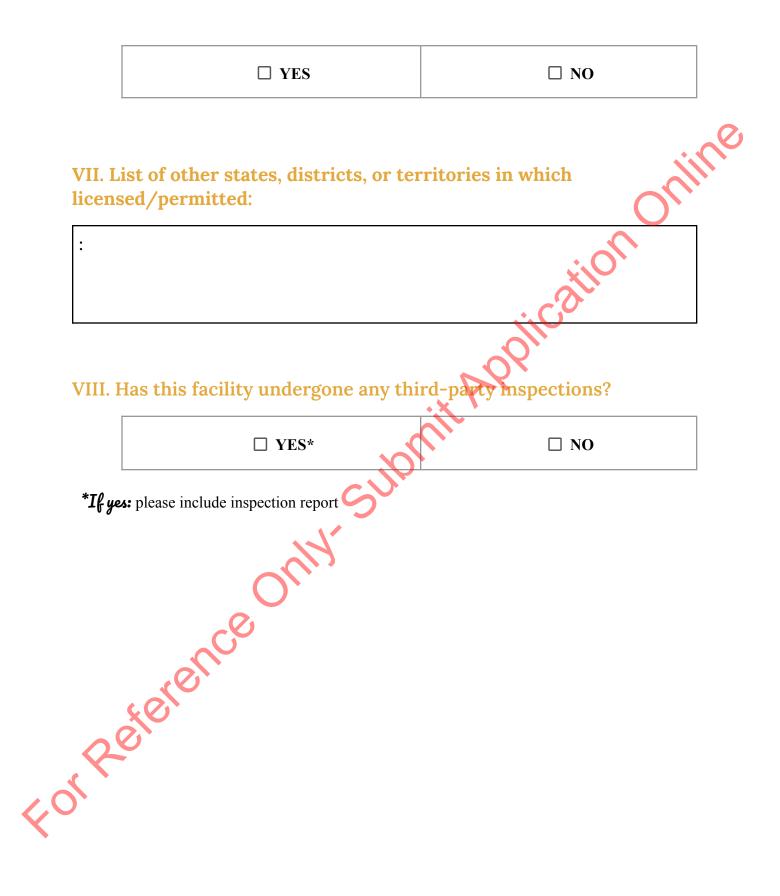












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I hereby certify that the foregoing is true and correct to the best of my knowledge. If the registration herein applied for is granted, I certify that this business will be conducted in full compliance with all applicable federal and state laws and that I will make available any or all records required by law to the extent authorized by law.

Signature and Title of Owner/ Manager:

I hereby certify that the above Renewal Application for Wholesaler was signed, subscribed and

sworn to before me this ______ day of ______, 20_____

By:

Signature:

My Commission Expires _____ State of

Changes in the above information must be submitted in writing with the appropriate application fee to the Board office within thirty (30) days.

**KENTUCKY** 











Form 6/2023

Date:

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 <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>
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 Pharma	icy:	• 		
Physical Address	of Pharmacy:			
CITY:	STATE:	COUNTY:	ZIP:	
Email:				
Phone number:				











Website Addre	ss:		
Mailing Addre	ss of Pharmacy:		00
CITY:	STATE:	COUNTY:	ZIP:
			icali
. Check and	l complete one o	f the following an	tateach proper fee:
□ <u>New Fa</u>	<u>cility</u> → \$150.00	it P	
Proposed date	of Opening:	ion"	
	(Filed with	1 board 30 days in advance o	f opening)
□ <u>Change</u>	of Ownership -+\$	150.00	
Proposed date	of acquisition:		
Name of previ	owner(s):		
(Please include d	-	change, including type of tr ucture of the transfer)	ansaction, date of transaction and
Name of previ	etailed explanation of the		ansaction, date of transaction











Date of Proposed Relocation:

Previous Address:

#### $\Box \underline{Name Change} \rightarrow NO CHARGE$

Previous Name:

#### **III. Ownership:**

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

6

- □ Sole Proprietor
- □ Partnership
- $\Box$  LLC
- $\Box$  Corporation
- $\Box$  Other

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

	Name:	Title:
	Name:	Title:
3.		











	Name:		Title:		
4.			I		
	Name:		Title:		Ś
5.					
	Name:		Title:	<	Ó,
	(Use suppler	mental information page if nec	essary)	·. 0	•
any	las any owner , member other agency related to macy?				· · · · · · · · · · · · · · · · · · ·
	□ YES*			0	
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* <b>If ye</b> :		Submi		<b>)</b>	
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· · · · · · · · · · · · · · · · · · ·	A: Please explain below	Subm S I.C.), Pharmacist(s KY License	), Interns a		Key
· · · · · · · · · · · · · · · · · · ·	A: Please explain below		), Interns a	and	Key
V. Ph Tech	A: Please explain below		), Interns a	and	 Key











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Kentucky Pha	rmacy Regulati pharmacist po		205 requires pl es and changes			the Board of al
VI Name	and title o	f each nor	nharma	ist with k	a state	pharmac
Name:			- pilai illac	Title		pilai iliacy
Name:				Title:		
Name:			5	Title:		
Name:			SUL	Title:		
Name:				Title:		
Name:		-Up		Title:		
	<u>_</u> @	(Use supplemer	ntal information p	bage if necessary	)	
	lule of Hor	Irs:				
VII. Sched	SV -			0 1		( 201 <b>0</b>
	.C. must notify t	the Board within	fourteen (14) da	ys of any change	es in scheduled h	ours.)
	P.C. must notify t	the Board within	fourteen (14) da	ys of any change <u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>











CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
★Please i	indicate if c	losed for lur	nch:			
previous manage	sly identif ment or s	ied in this	applicatio	all individ on, respon	uals, other sible for p s Manager	
Name:			A	Affiliation:	<u>56,.</u>	
Address:			x	MIL		
CITY:		STATE:	Scou	NTY:	ZIP:	
		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	Y _			
Name:			A	Affiliation:		
Address:	en)				
CITY:	(O)	STATE:	COUI	NTY:	ZIP:	
Name:			A	Affiliation:		

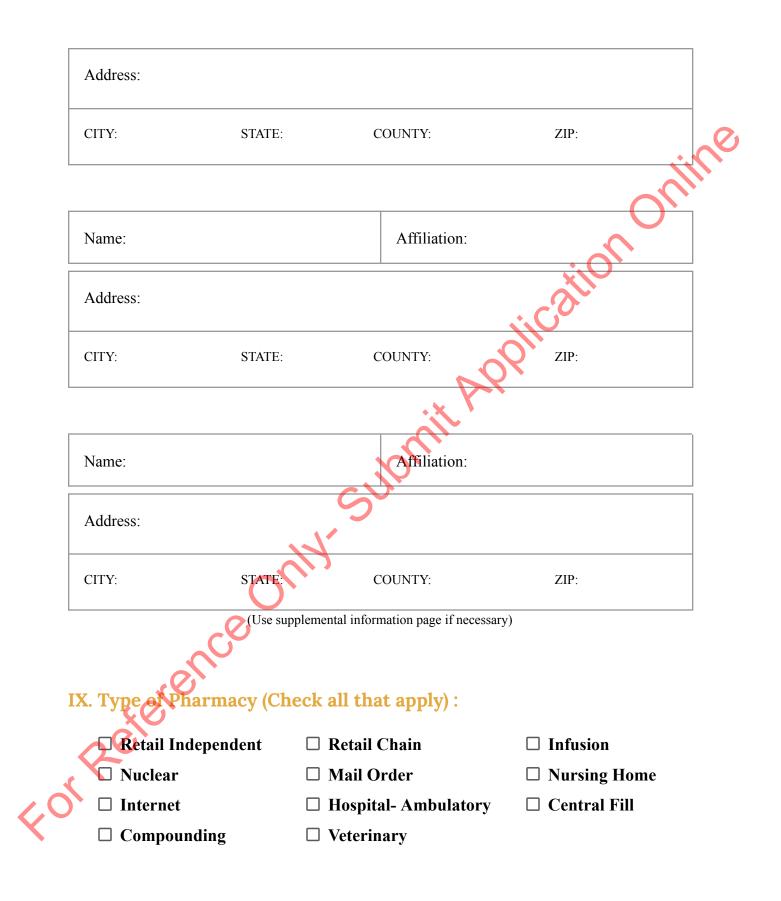












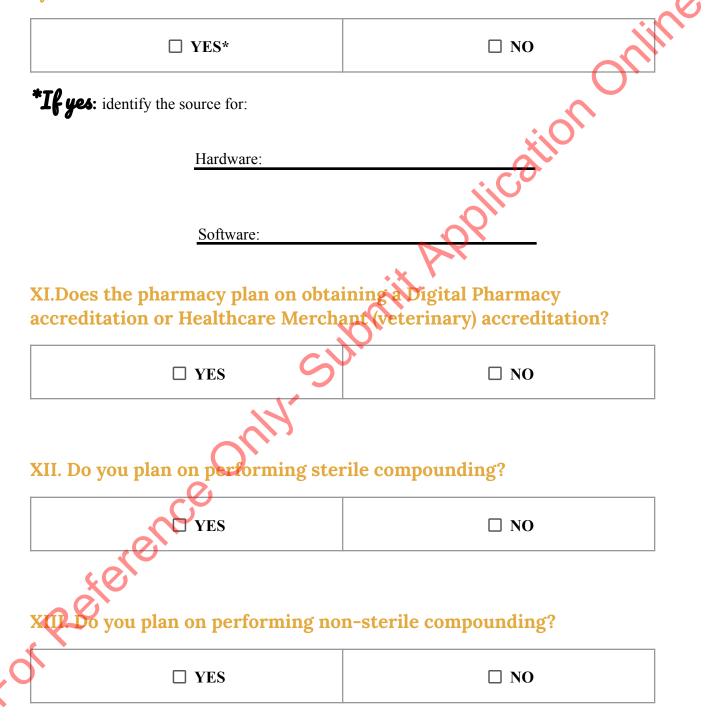








X.Does pharmacy currently utilize an automated data processing system?













XIV. Does this pharmacy stock any emergency medication kits?

□ YES	
7. Does this pharmacy stock any entucky?	y long-term care facility in U
□ YES	
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/I. Does this pharmacy utilize a spensing?	ny automation for prescription
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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:			
and sworn to before me this, 20, 3y: Signature: My Commission ExpiresState of Aure of Owner:State of Date hereby certify that the above Application for Resident Pharmacy Permit was signed, s and sworn to before me thisday of, 20, By: Signature:	hereby cortify that the above Application for Pagi	dont Dharmaay D	armit was signed subs
By: Signature: My Commission Expires My Commission Expires State of	I hereby certify that the above Application for Resid	dent Pharmacy Po	ermit was signed, subs
By: Signature: My Commission Expires State of My Commission Expires State of Date Date I hereby certify that the above Application for Resident Pharmacy Permit was signed, s and sworn to before me thisday of, 20, By: Signature:	and sworn to before me this	day of	, 20
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I hereby certify that the above Application for Resident Pharmacy Permit was signed, s and sworn to before me thisday of, 20 By: Signature:		State of _	///////////////////////////////////////
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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 <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>
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 Pharma	icy:	• 		
Physical Address	of Pharmacy:			
CITY:	STATE:	COUNTY:	ZIP:	
Email:				
Phone number:				











Website Addre	ss:		
Mailing Addre	ss of Pharmacy:		00
CITY:	STATE:	COUNTY:	ZIP:
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. Check and	l complete one o	f the following an	tateach proper fee:
□ <u>New Fa</u>	<u>cility</u> → \$150.00	it P	
Proposed date	of Opening:	ion"	
	(Filed with	1 board 30 days in advance o	f opening)
□ <u>Change</u>	of Ownership -+\$	150.00	
Proposed date	of acquisition:		
Name of previ	owner(s):		
(Please include d	-	change, including type of tr ucture of the transfer)	ansaction, date of transaction and
Name of previ	etailed explanation of the		ansaction, date of transaction











Date of Proposed Relocation:

Previous Address:

$\Box \underline{Name Change} \rightarrow NO CHARGE$

Previous Name:

III. Ownership:

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

6

- □ Sole Proprietor
- □ Partnership
- \Box LLC
- \Box Corporation
- \Box Other

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

	Name:	Title:
	Name:	Title:
3.		











	Name:		Title:		
4.			I		
	Name:		Title:		Ś
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	Name:		Title:	<	Ó,
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any	las any owner , member other agency related to macy?				· · · · · · · · · · · · · · · · · · ·
	□ YES*			0	
If ye	YES	Submi)	
* If ye :		Submi)	
· · · · · · · · · · · · · · · · · · ·		Submi S I.C.), Pharmacist(s			
· · · · · · · · · · · · · · · · · · ·	A: Please explain below	Subm S I.C.), Pharmacist(s KY License), Interns a		Key
· · · · · · · · · · · · · · · · · · ·	A: Please explain below), Interns a	and	Key
V. Ph Tech	A: Please explain below), Interns a	and	 Key











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Name:			5	Title:		
Name:			SUL	Title:		
Name:				Title:		
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	lule of Hor	Irs:				
VII. Sched	SV -			0 1		(201 7
	.C. must notify t	the Board within	fourteen (14) da	ys of any change	es in scheduled h	ours.)
	P.C. must notify t	the Board within	fourteen (14) da	ys of any change <u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>











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Name:			A	Affiliation:	<u>56,.</u>	
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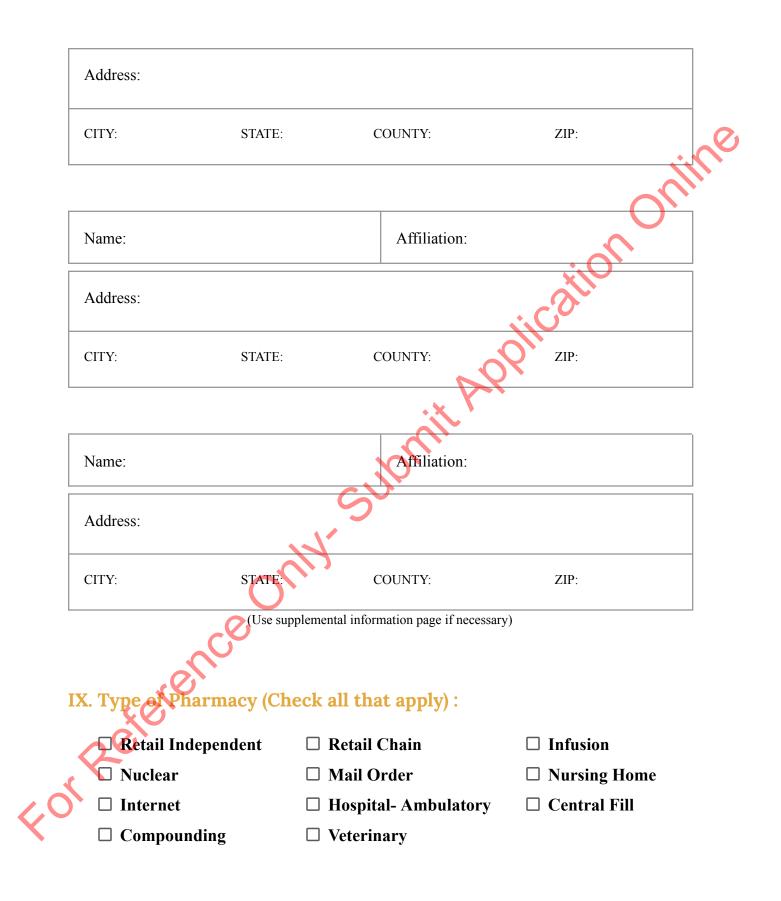












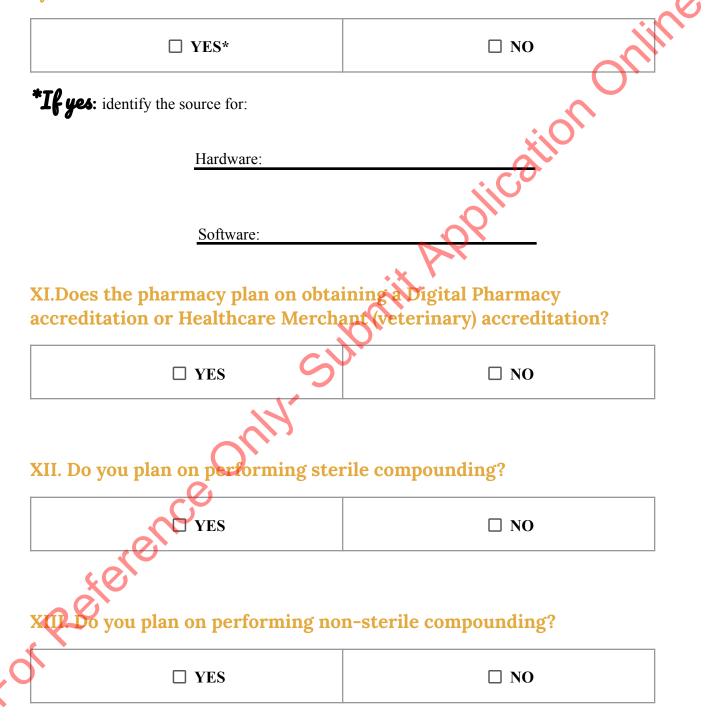








## X.Does pharmacy currently utilize an automated data processing system?













#### XIV. Does this pharmacy stock any emergency medication kits?

□ YES	
Does this pharmacy stock any nucky?	long-term care facility in
□ YES	
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hereby certify that the above Application for Residen	t Dharmaay D	mit was signed a
nereby certify that the above Application for Residen	n Pharmacy Pe	erinit was signed, st
and sworn to before me thisda	y of	, 20
By:		
Signature:		
My Commission Expires	State of	
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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 Special Limited Pharmacy Permit Charitable Pharmacy Renewal

. .

Enclose a check or money order for \$150.00, made payable to 'Kentucky State Treasurer' or pay online at <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>. Please print legibly and complete this application; including the required original signature and return no later than June 30th.

I. Facility Information:	omit		
Name of Facility:	SUP		
Kentucky Permit No.:	Y		
Physical Address of Facility:			
CITY: STATE:	COUNTY:	ZIP:	
Email Address:			
Phone Number:			
Fax Number:			

Form 6/2023

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#### **II. Ownership:**

ine How is the pharmacy registered with the Kentucky Secretary of Star

- $\Box$  Sole Proprietor
- □ Partnership
- $\Box$  LLC
- □ Corporation
- $\Box$  Other

# plication $\star$ $\star$ Name and title for each owner/officer/member, including any professional designation (e.g. Pres, John Jones, PharmD):

Name:			<i>,j0,</i>	Title:		
Name:			5	Title:		
Name:		~73		Title:		
Name:		0		Title:		
Name:	6			Title:		
Name:				Title:		
2 exte		(Use supplemen	tal information p	age if necessary	)	
III. Sched	ule of Hou	rs:				
(P.I	.C. must notify tl	he Board within	fourteen (14) day	vs of any changes	s in scheduled ho	ours.)

	<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>
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CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
<b>24</b> HOURS	D 24 HOURS	D 24 HOURS	<b>24</b> HOURS	<b>24</b> HOURS	<b>24</b> HOURS	D 24 HOURS
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1. Pha Name:	rmacist in (	Charge (P.I.		eense No.:		
Note: 201 K	AR 2:205 require	-	-in-charge to not		hin fourteen [14	] calendar days of
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lice	ensed/reg	stered wit	h the Boar		right	Mumbor
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	Nam	e:		Pharma	acy Technic	ian):
1.	S.					
2.						
3.						

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⁽Use supplemental information page if necessary)

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

Name:		Title:	
Address:	14		
CITY:	STATE.	COUNTY:	ZIP:
	nce		
Name:	0	Title:	
Address:			
CITY:	STATE:	COUNTY:	ZIP:











Form 6/2023

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Address:			
CITY:	STATE:	COUNTY:	ZIP:
Name:		Title:	ation
Address:			RING
CITY:	STATE:	COUNTY:	ZIP:
Name:		Title:	
Address:	ally		
CITY:	STATE:	COUNTY:	ZIP:
		ental information page if necessar	ry)
4. <b>Oisciplin</b>	ne:		
		r been subject to discip syment in a pharmacy?	











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# *If yes: Please explain below

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TEAM TEAM





Form 6/2023

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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.

nature of Pharmacist-in-Charge:		Date:
I hereby certify that the above Renewal Application	on for Resident Pharm	acy Permit was signe
subscribed and sworn to before me this	day of	, 2 <mark>0</mark>
By:	<i>b</i> ,	
Signature:		
My Commission Expires	State of	
nature of Owner:	- nit	Date:
I hereby certify that the above Renewal Application	on for Resident Pharm	acy Permit was signed
I hereby certify that the above Renewal Application subscribed and sworn to before me this		
subscribed and sworn to before me this		

TEAM TEAM







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 Special Limited Pharmacy Permit Charitable Pharmacy Renewal

. .

Enclose a check or money order for \$150.00, made payable to 'Kentucky State Treasurer' or pay online at <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>. Please print legibly and complete this application; including the required original signature and return no later than June 30th.

I. Facility Information:	omit		
Name of Facility:	SUP		
Kentucky Permit No.:	Y		
Physical Address of Facility:			
CITY: STATE:	COUNTY:	ZIP:	
Email Address:			
Phone Number:			
Fax Number:			

Form 6/2023

EAM







#### **II. Ownership:**

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- $\Box$  Sole Proprietor
- □ Partnership
- $\Box$  LLC
- □ Corporation
- $\Box$  Other

# plication $\star$ $\star$ Name and title for each owner/officer/member, including any professional designation (e.g. Pres, John Jones, PharmD):

Name:			<i>,j0,</i>	Title:		
Name:			5	Title:		
Name:		~73		Title:		
Name:		0		Title:		
Name:	6			Title:		
Name:				Title:		
2 ete		(Use supplemen	tal information p	age if necessary	)	
III. Sched	ule of Hou	rs:				
(P.I	.C. must notify tl	he Board within	fourteen (14) day	vs of any changes	s in scheduled ho	ours.)

	<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>
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OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
<b>24</b> HOURS	D 24 HOURS	D 24 HOURS	<b>24</b> HOURS	<b>24</b> HOURS	<b>24</b> HOURS	24 HOURS
★Please inc	licate if closed	for lunch:		until		0
		EMPLO	YEE INF	ORMATIC	N:ICOL	
1. Pha Name:	rmacist in (	Charge (P.I.		eense No.:		
Note: 201 K	AR 2:205 require	-	-in-charge to not	-	thin fourteen [14	] calendar days of
		e comple			ees	
lice	ensed/reg	stered wit	h the Boar		ristration	Number 1
			(I	Pharmacist,	egistration Pharmacist	
	Nam	e:		Pharma	acy Technic	ian):
1.	<u>v</u>					
2.						
3.						

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⁽Use supplemental information page if necessary)

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

Name:		Title:	
Address:	24		
CITY:	STATE.	COUNTY:	ZIP:
	nce		
Name:	0	Title:	
Address:			
CITY:	STATE:	COUNTY:	ZIP:











Form 6/2023

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Address:			
CITY:	STATE:	COUNTY:	ZIP:
Name:		Title:	ation
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**KENTUCKY** 



# *If yes: Please explain below

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TEAM TEAM





Form 6/2023

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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.

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By:	<i>b</i> ,	
Signature:		
My Commission Expires	State of	
nature of Owner:	- nit	Date:
I hereby certify that the above Renewal Application	on for Resident Pharm	acy Permit was signed
I hereby certify that the above Renewal Application subscribed and sworn to before me this		
subscribed and sworn to before me this		

TEAM TEAM







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 Special Limited Pharmacy Permit Charitable Pharmacy

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>. 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 Info	rmation:	SUD.		
Name of Facility				
Physical Address	s of Facility:			
CITY:	STATE:	COUNTY:	ZIP:	
Mailing Address	of Facility:			
СІТУ:	STATE:	COUNTY:	ZIP:	











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Phone Number:	
Fax number:	00
Website Address:	noit
	ical.
<ul> <li>Check and complete one of the fol</li> <li>□ <u>New Facility</u> → \$150.00</li> </ul>	nowing and accarn proper ree:
Proposed date of Opening:	mit
(Filed with board 30	days in advance of opening)
OR Current Permit No. :	Exp. Date:
(In State where pro	esently located)
□ <u>Change of Ownership</u> → \$0	
Proposed date of Acquisition:	
Name of Previous Owner(s):	
(Confirmation statement of p	revious must be attached)











Date of Proposed Relocation:

Previous Address:

#### □ <u>Name Change</u> → \$0

Previous Name:

#### **III. Ownership:**

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

Subr

- □ Sole Proprietor
- □ Partnership
- $\Box$  LLC
- $\Box$  Corporation
- $\Box$  Other

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

Name:	Title:
Name:	Title:









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### IV. Pharmacist in Charge:

cense No.: rmacist in charge to notify the Board within ist personnel changes. of pharmacy employees: License No. :
of pharmacy employees:
of pharmacy employees:
License No. :
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Name:	Title:	
Name:	Title:	ine
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Name:	Title:	
	(Use supplemental information page if necessary)	
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#### VII. Schedule of Hours:

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

<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	THURSDAY	FRIDAY	<u>SATURDAY</u>	<u>SUNDAY</u>
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

 $\star$  Please indicate if closed for lunch:

# VIII. Discipline:

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

□ YES*	
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*If yes: Please explain below

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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 nereby certify that the above Application for Resident Pharmacy Permit was signed, subscrib	ereby certify that the above Application for Resident Pharmacy Per	rmit was signed, subscribe
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and sworn to before me this	day of	, 20
By:	JOI.	$\mathbb{S}^2$
Signature:	2	
My Commission Expires	State of	
Signature of Owner:	WE FAL	Date:
I hereby certify that the above Application for and sworn to before me this By:	- BPAR VS	24
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 Special Limited Pharmacy Permit Charitable Pharmacy

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal</u>. 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 Info	rmation:	SUD.		
Name of Facility				
Physical Address	s of Facility:			
CITY:	STATE:	COUNTY:	ZIP:	
Mailing Address	of Facility:			
СІТУ:	STATE:	COUNTY:	ZIP:	











FAM



Phone Number:	
Fax number:	00
Website Address:	noit
	ical.
<ul> <li>Check and complete one of the fol</li> <li>□ <u>New Facility</u> → \$150.00</li> </ul>	nowing and accarn proper ree:
Proposed date of Opening:	mit
(Filed with board 30	days in advance of opening)
OR Current Permit No. :	Exp. Date:
(In State where pro	esently located)
□ <u>Change of Ownership</u> → \$0	
Proposed date of Acquisition:	
Name of Previous Owner(s):	
(Confirmation statement of p	revious must be attached)











Date of Proposed Relocation:

Previous Address:

#### □ <u>Name Change</u> → \$0

Previous Name:

#### **III. Ownership:**

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

Subr

- □ Sole Proprietor
- □ Partnership
- $\Box$  LLC
- $\Box$  Corporation
- $\Box$  Other

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

Name:	Title:
Name:	Title:









Form 6/2023



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### IV. Pharmacist in Charge:

cense No.: rmacist in charge to notify the Board within ist personnel changes. of pharmacy employees: License No. :
of pharmacy employees:
of pharmacy employees:
License No. :
License No. :
License No. :
·License No
License No. :
License No. :
License No. :
License No. :
e if necessary)
t with keys to the pharmacy:
· · · · · · · · · · · · · · · · · · ·
-













Name:	Title:	
Name:	Title:	ine
		O
Name:	Title:	
	(Use supplemental information page if necessary)	
	iico	

#### VII. Schedule of Hours:

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

<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	THURSDAY	FRIDAY	<u>SATURDAY</u>	<u>SUNDAY</u>
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

 $\star$  Please indicate if closed for lunch:

# VIII. Discipline:

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

□ YES*	
--------	--

*If yes: Please explain below

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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 nereby certify that the above Application for Resident Pharmacy Permit was signed, subscrib	ereby certify that the above Application for Resident Pharmacy Per	rmit was signed, subscribe
-----------------------------------------------------------------------------------------------	--------------------------------------------------------------------	----------------------------

and sworn to before me this	day of	, 20
By:	Jo'	$\mathbb{S}^2$
Signature:	2	
My Commission Expires	State of	
Signature of Owner:	WE FAL	Date:
I hereby certify that the above Application for and sworn to before me this By:	- BPAR VS	24
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 Special Limited 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 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.

Name of Faci	lity:			
Physical Add	ress of Facility:			
CITY:	STATE:	COUNTY:	ZIP:	
Mailing Addr	ess of Facility:			
CITY:	STATE:	COUNTY:	ZIP:	









Fax Number:	•
Website Address:	Or
. Check and complete	one of the following and attach proper fee:
□ <u>New Facility</u> → \$150	0.00
Proposed date of Opening:	P6K
[]	Filed with board 30 days in advance of opening)
<u><b>OR</b></u> Current Permit No. :	Exp. Date:
	(In State where presently located)
□ <u>Change of Ownersh</u>	<u>tip</u> →\$150.00
Proposed date of Acquisition:	
Name of Previous Owner(s):	
Please include detailed explanation	on of the change, including type of transaction, date of transaction and structure of the transfer
Change of Address/	<u>Location</u> → \$150.00

KENTUCKY KENTUCKY









Previous Address:

# tine □ <u>Name Change</u> → NO CHARGE Previous Name: ation **III. Ownership:** How is the pharmacy registered with the Kentucky Secretary of State? SubmitA □ Sole Proprietor □ Partnership $\Box$ LLC □ Corporation $\Box$ Other $\star$ $\star$ Name and title for each owner/officer/member, including professional designation (e.g. Pres. John Jones, PharmD): Title: Name: Title: Name: Title: Name: Title: Name:

Name:

Name:

(Use supplemental information page if necessary)









Title:

Title:



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

Name KY License No.:	Please explain below			0,
Name KY License No.:				
Name     KY License No.:			Alle	
V. Pharmacist in Charge (P.I.C.), Pharmacist (s), Interns, and Technicians: Name KY License No.: P.I.C. : Comparison of the second				
Name     KY License No.:			2	
Name KY License No.:	rmacist in Charge (PIC) P	harmacist(s	Interns and	
			, meerns, and	
	N		1/1/1· N	
	Name	$\sim$	KY License No.:	
Ce only		2		
		-		
(Use supplemental information page if necessary)			222222	
Kentucky Pharmacy Regulation 201 KAR 2:205 requires the Pharmacist in charge to notify the Board with fourteen (14) calendar days of all pharmacist personnel changes.				

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





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MONDAY	<u>TUESDAY</u>	WEDNESDAY	<u>THURSDAY</u>	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>	
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	5
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	
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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.

nature of Pharmacist-in-Charge:		Date:
I hereby certify that the above Application for	or Pharmacy Permi	t was signed, subscribed an
sworn to before me this	day of	, 20
By:		
Signature:		
My Commission Expires	State o	f
nature of Owner:	ML .	Date:
nature of Owner: I hereby certify that the above Application for	or Pharmacy Permi	
20×		t was signed, subscribed an
I hereby certify that the above Application for		t was signed, subscribed an
I hereby certify that the above Application for		t was signed, subscribed an
I hereby certify that the above Application for sworn to before me this	day of	t was signed, subscribed an







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Name of Faci	lity:			
Physical Add	ress of Facility:			
CITY:	STATE:	COUNTY:	ZIP:	
Mailing Addr	ess of Facility:			
CITY:	STATE:	COUNTY:	ZIP:	









Phone Number:	
Fax Number:	
Website Address:	Or
Check and complete	one of the following and attach proper fee:
□ <u>New Facility</u> → \$150	D.00
Proposed date of Opening:	R66
(F	Filed with board 30 days in advance of opening)
<b><u>OR</u></b> Current Permit No. :	Exp. Date:
	(In State where presently located)
□ <u>Change of Ownersh</u>	<u>ip</u> →\$150.00
Proposed date of Acquisition:	
Name of Previous Owner(s):	
Please include detailed explanatio	on of the change, including type of transaction, date of transaction and structure of the transfer
□ <u>Change of Address/I</u>	Location → \$150.00

KENTUCKY KENTUCKY





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Previous Address:

# tine □ <u>Name Change</u> → NO CHARGE Previous Name: ation **III. Ownership:** How is the pharmacy registered with the Kentucky Secretary of State? SubmitA □ Sole Proprietor □ Partnership $\Box$ LLC □ Corporation $\Box$ Other $\star$ $\star$ Name and title for each owner/officer/member, including professional designation (e.g. Pres. John Jones, PharmD): Title: Name: Title: Name: Title: Name: Title: Name:

Name:

Name:

(Use supplemental information page if necessary)









Title:

Title:



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

	<u> </u>
Technicians:	
Technicians:	
V. Pharmacist in Charge (P.I.C.), Pharmacist(s), Interns, and Technicians: Name KY License No.:	
Fechnicians:	
Technicians:	
Name KY License No.:	
Name KY License No.:	
P.I.C. :	
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(P.I.C. must notify the Board within fourteen (14) days of any changes in scheduled hours.)





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	OPEN: CLOSE: ate if closed t	OPEN: CLOSE: for lunch:	OPEN: CLOSE:	OPEN: CLOSE: unti	OPEN: CLOSE:	OPEN: CLOSE:
			CLOSE:			CLOSE:
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					licon	<u>,                                     </u>
	S	Supplemer	ntal Inform	nation Pag	e.	
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	nce	<b>)</b>				
Reie						

KENTUCKY KENTUCKY











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.

nature of Pharmacist-in-Charge:	Date:
I hereby certify that the above Application for Pharm	nacy Permit was signed, subscribed a
sworn to before me thisday o	of, 20
By:	
Signature:	
My Commission Expires	State of
nature of Owner:	Date:
nature of Owner: I hereby certify that the above Application for Pharm	JOUR //
.0	nacy Permit was signed, subscribed a
I hereby certify that the above Application for Pharm	nacy Permit was signed, subscribed a
I hereby certify that the above Application for Pharm	nacy Permit was signed, subscribed a
I hereby certify that the above Application for Pharm sworn to before me thisday of By:	nacy Permit was signed, subscribed a







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### Application to Operate as a Third Party Logistics Provider

Print legibly. Make check or money order payable to Kentucky State Treasurer or payment can be made online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal. Mail completed notarized application to the above address with required documentation. Incomplete applications will be returned. Licenses expire June 30 following the date of issuance.

J	I. Facility Inform	ation:	SUL					
	Name of Facility:	OUL						
	Physical Address of	Facility:						
	CITY:	STATE:	COUNTY:	ZIP:				
	Mailing Address of Facility:							
Ó	CITY:	STATE:	COUNTY:	ZIP:				











Email:		
Phone number:		
Fax Number:		5
Website Address:	70:	
	omplete one of the following: Party Logistics $\rightarrow$ \$400.00	
Proposed date of op		
Dependence of a contract of a	<u>Change</u> → \$150.00 acquisition:	
	owner(s):	
Proposed date of ad Name of previous	equisition:	
Proposed date of ad Name of previous	equisition: owner(s): (Confirmation statement from previous owner must be attached) <u>Address/Location</u> → \$150.00	











## □ <u>Name Change</u> → NO CHARGE

Previous Name:	
II. Registration Numbers a	nd Expiration Dates:
DEA:	Exp. Date:
	iiCo
FDA:	Exp. Date:
V. Name, phone, and email	of the Facility Contact Person:
Name:	
Title:	
Phone Number:	
Email:	
20	
/. Qualifying Questions:	

**1.** Has applicant, or any owner [s], partner [s], officer [s], or agent of the applicant, ever been convicted of any felony under federal, state, and/or local laws?











*If yes: please provide explanation below:	
Explanation:	
	O`
2. Has applicant, or any owner [s], part	ner [s], officer [s], or agent of the
applicant, ever had a license or perm	
federal, state, or local government?	
□ YES*	
*If yes: please provide explanation below:	<u> </u>
Explanation:	X
	•
C V	•
3. Has applicant, or any owner [s], part	
applicant, ever been convicted under	federal, state and/or local drug laws,
	federal, state and/or local drug laws,
applicant, ever been convicted under including drug samples and wholesal	federal, state and/or local drug laws,
applicant, ever been convicted under including drug samples and wholesal controlled substances?	federal, state and/or local drug laws, e or retail drug distribution of
applicant, ever been convicted under including drug samples and wholesal controlled substances? YES* *If yes: please provide explanation below:	federal, state and/or local drug laws, e or retail drug distribution of
applicant, ever been convicted under including drug samples and wholesal controlled substances?	federal, state and/or local drug laws, e or retail drug distribution of
applicant, ever been convicted under including drug samples and wholesal controlled substances? YES* *If yes: please provide explanation below:	federal, state and/or local drug laws, e or retail drug distribution of
applicant, ever been convicted under including drug samples and wholesal controlled substances? YES* *If yes: please provide explanation below:	federal, state and/or local drug laws, e or retail drug distribution of
applicant, ever been convicted under including drug samples and wholesal controlled substances?	federal, state and/or local drug laws, e or retail drug distribution of
<ul> <li>applicant, ever been convicted under including drug samples and wholesal controlled substances?</li> <li>YES*</li> <li>*If yes: please provide explanation below:</li> <li>Explanation:</li> <li>4. Has applicant, officer, partner or direction of the second seco</li></ul>	federal, state and/or local drug laws, e or retail drug distribution of











*If yes: please provide license or permit number below

License/Permit No .:

## **VI. Schedule of Hours:**

<u>MONDAY</u>	<u>TUESDAY</u>	WEDNESDAY	<u>THURSDAY</u>	<u>FRIDAY</u>	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
VII. Owne	ership:		- Joh			

## VII. Ownership:

How is the facility registered with the Secretary of State?

- □ Sole Proprietor
- □ Partnership
- □ LLC
- □ Corporation
- $\Box$  Other

 $\star$   $\star$  Please provide the following information for each owner/partner/director/member/officer:

Name:	Title:











Phone number(Business):		
Phone number(Home):		0
Social Security Number:	Date of Birth:	no _i .
Federal Employee ID Number:		icali
Address (Business):	29	<b>S</b> ,
CITY: STATE:	COUNTY.	ZIP:
Address (Home):	Sup	
CITY: STATE:	COUNTY:	ZIP:
Name:	Title:	
Email		
Phone number(Business):		











Social Security Nu	umber:	Date of Birth:	
Federal Employee	ID Number:		
Address (Business	e):		OUI
CITY:	STATE:	COUNTY:	ZIP:
Address (Home):			dicat
CITY:	STATE:	COUNTY:	ZIP:
3.		mit	
Name:		Title:	
Email:	24		
Phone number(Bu	siness):		
Phone number(Ho	me):		
Social Security Nu	umber:	Date of Birth:	
Federal Employee	ID Number:		
Address (Business	;):		











CITY:	STATE:	COUNTY:	ZIP:
Address (Home)	:		
CITY:	STATE:	COUNTY:	ZIP:
1.			10/1
Name:		Title:	icali
Email:			29,
Phone number(E	Business):	dit t	
Phone number(H	Iome):	SUDI	
Social Security N	Number:	Date of Birth:	
Federal Employe	ee ID Number:		
Address (Busine	\$5):		
CITY:	STATE:	COUNTY:	ZIP:
Address (Home)	:		
CITY:	STATE:	COUNTY:	ZIP:











Email: Phone number(Business): Phone number(Home): Social Security Number: Dat Federal Employee ID Number: Address (Business): CITY: STATE: COUNT Address (Home):	of Birth:
Phone number(Home): Social Security Number: Dat Federal Employee ID Number: Address (Business): CITY: STATE: COUNT	
Social Security Number: Dat Federal Employee ID Number: Address (Business): CITY: STATE: COUNT	
Federal Employee ID Number: Address (Business): CITY: STATE: COUNT	
Address (Business): CITY: STATE: COUNT	700.
CITY: STATE: COUNT	710.
	710.
Address (Home):	ZIP:
CITY: STATE: COUNT	ZIP:
(Use supplemental information p	
ID. List of state, districts, or territorie censed/permitted:	in which











# IX.What was the date of the last facility inspection?

*If perform	ed by an entity other than the Kentucky Board of Pharmacy, please provide
-	a copy of the inspection report.
	Supplemental Information Page:
	NV.
	<b>2</b> *
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eler	
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Pursuant to KRS 315.121, the Board may refuse to issue or otherwise discipline any licensee or permit holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a permit.

I hereby certify that the foregoing is true and correct to the best of my knowledge. If the license applied for is granted, I certify that this business will be conducted in full compliance with all applicable federal and state laws and that I will make available any or all records required by law to the extent authorized by law.

#### Signature of Owner/Officer and Title:

I hereby certify that the above Application to Operate as a Third Party Logistics Provider was

signed, subscribed and sworn to before me this _____day of _____, 20____.

Signature:

My Commission Expires ____

State	of	











Date:

### **REQUIRED DOCUMENTATION:**

□ Completed application

Copy of DEA Registration

Copy of Current Inspection Report by FDA, NABP or Board

Copy of FDA Third Party Logistics Registration and other state license (if applicable)

□ Legal proof of name change for Section 2

.ur ur over submit subm Confirmation Statement of former owner for Section 2











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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 or Third Party Logistics Provider License Renewal

Enclose a check or money order for \$400.00, made payable to 'Kentucky State Treasurer' or payment can be made online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal. Please print legibly and complete this application; including the required original signature and return to the Board office no later than June 30th.

I. Facility Informa	tion:	SUP		
Facility Name:				
Address:	e e			
CITY:	STATE:	COUNTY:	ZIP:	
Email Address:				
Website Address:				
Phone Number:				











Fax Number:

## **II. Ownership:**

How is this facility registered with the Secretary of State?

- □ Sole Proprietor
- □ Partnership
- $\Box$  LLC
- □ Corporation
- $\Box$  Other

onime onime onime onime onime  $\star \star$  Please provide the following information for each owner/partner/director/member/officer:

<i>bi</i> .
Title:
Date of Birth:











CITY:	STATE:	COUNTY:	ZIP:
Address(Busine	ss):		
CITY:	STATE:	COUNTY:	ZIP:
2.			noi
Name:		Title:	icali
Email:		N	2 ⁹ ,
Phone number(	Business):	ditt	
Phone number(	Home):	SUDI	
Social Security	Number:	Date of Birth:	
Federal Employ	ee ID Number:		
Address(Home)	nce		
CITY:	STATE:	COUNTY:	ZIP:
Address(Busine	ss):		
CITY:	STATE:	COUNTY:	ZIP:











Name:	Title:	
Email:		Ś
Phone number(Business):		
Phone number(Home):		ailor
Social Security Number:	Date of Birth:	RIP
Federal Employee ID Number:	itA	
Address(Home):	- 10m	
CITY: STATE:	COUNTY:	ZIP:
Address(Business):		
CITY: STATE:	COUNTY:	ZIP:
4.		
Name:	Title:	
Email:		
Phone number(Business):		











Phone number(1			
Social Security	Number:	Date of Birth:	
Federal Employ	ee ID Number:		0
Address(Home)	:		noi
CITY:	STATE:	COUNTY:	ZIP:
Address(Busine	ss):	, Pr	8.
CITY:	STATE:	COUNTY:	ZIP:
		SUL	
Name:	AL.	Title:	
Email:			
Phone number()	Business):		
Phone number(1	Home):		
Social Security	Number:	Date of Birth:	
Federal Employ	ee ID Number:		











Address(Home):			
CITY:	STATE:	COUNTY:	ZIP:
Address(Business):			OUN
CITY:	STATE:	COUNTY:	ZIP:
	(Use suppleme	ental information page if necessa	ry)

## **III. Schedule of Hours:**

III. Sched	ule of Hou	rs:		29	Silce	
<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	THURSDAY	FRIDAY	<u>SATURDAY</u>	<u>SUNDAY</u>
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

# IV. Registration Numbers and Expiration Dates:

DEA:	Exp. Date:	
FDA:	Exp. Date:	

V. Name, phone, and email of the Facility Contact Person:











Title:		
Phone Number		Or
Email:		ion
1. H fe re	ave any owner [s], partner [s], officer [s] lony under federal, state, and/or local la ported to the Board? UYES* please provide explanation below: tion:	
re	as any owner [s], partner [s], officer [s]	l, state, or local government that











	3. What was the date of the last facility inspection?
	Date:
	*If performed by an entity other than the Kentucky Board of Pharmacy, please provide a copy of the inspection report.
	Supplemental Information Page:
	SUN
	OUIN
	serence
$\frac{1}{\sqrt{2}}$	
J	











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I hereby certify that the foregoing is true and correct to the best of my knowledge. If the registration herein applied for is granted, I certify that this business will be conducted in full compliance with all applicable federal and state laws and that I will make available any or all records required by law to the extent authorized by law.

SU

#### Signature of Owner:

I hereby certify that the above Renewal Application to	Operate as a Third	Party Logistics Provider	was
signed, subscribed and sworn to before me this	day of	, 20	
By:			
Signature:			
My Commission Expires	State	of .	











Date:

nine

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 or Third Party Logistics Provider License Renewal

Enclose a check or money order for \$400.00, made payable to 'Kentucky State Treasurer' or payment can be made online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal. Please print legibly and complete this application; including the required original signature and return to the Board office no later than June 30th.

I. Facility Informa	tion:	SUP		
Facility Name:				
Address:	e e			
CITY:	STATE:	COUNTY:	ZIP:	
Email Address:				
Website Address:				
Phone Number:				











Fax Number:

## **II. Ownership:**

How is this facility registered with the Secretary of State?

- □ Sole Proprietor
- □ Partnership
- $\Box$  LLC
- □ Corporation
- $\Box$  Other

onime onime onime onime onime  $\star \star$  Please provide the following information for each owner/partner/director/member/officer:

<i>bi</i> .
Title:
Date of Birth:











CITY:	STATE:	COUNTY:	ZIP:	
Address(Busine	ss):			
CITY:	STATE:	COUNTY:	ZIP:	
2.			noi	
Name:		Title:	icali	
Email:		N	2 ⁹ ,	
Phone number(	Business):	ditt		
Phone number(	Phone number(Home):			
Social Security	Number:	Date of Birth:		
Federal Employ	ee ID Number:			
Address(Home)	nce			
CITY:	STATE:	COUNTY:	ZIP:	
Address(Busine	ss):			
CITY:	STATE:	COUNTY:	ZIP:	











Name:	Title:	
Email:		Ś
Phone number(Business):		
Phone number(Home):		ailor
Social Security Number:	Date of Birth:	RIP
Federal Employee ID Number:	itA	
Address(Home):	- 10m	
CITY: STATE:	COUNTY:	ZIP:
Address(Business):		
CITY: STATE:	COUNTY:	ZIP:
4.		
Name:	Title:	
Email:		
Phone number(Business):		











Phone number(Home):			
Social Security	Number:	Date of Birth:	
Federal Employ	ee ID Number:		0
Address(Home)	:		noi
CITY:	STATE:	COUNTY:	ZIP:
Address(Busine	ss):	, Pr	8.
CITY:	STATE:	COUNTY:	ZIP:
		SUL	
Name:	AL.	Title:	
Email:			
Phone number()	Business):		
Phone number(1	Home):		
Social Security	Number:	Date of Birth:	
Federal Employ	ee ID Number:		











Address(Home):			
CITY:	STATE:	COUNTY:	ZIP:
Address(Business):			OUN
CITY:	STATE:	COUNTY:	ZIP:
	(Use suppleme	ental information page if necessa	ry)

## **III. Schedule of Hours:**

III. Sched	ule of Hou	rs:		29	Silce	
<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	THURSDAY	FRIDAY	<u>SATURDAY</u>	<u>SUNDAY</u>
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

# IV. Registration Numbers and Expiration Dates:

DEA:	Exp. Date:	
FDA:	Exp. Date:	

V. Name, phone, and email of the Facility Contact Person:











Title:		
Phone Number		Or
Email:		ion
1. H fe re	ave any owner [s], partner [s], officer [s] lony under federal, state, and/or local la ported to the Board? UYES* please provide explanation below: tion:	
re	as any owner [s], partner [s], officer [s]	l, state, or local government that











	3. What was the date of the last facility inspection?
	Date:
	*If performed by an entity other than the Kentucky Board of Pharmacy, please provide a copy of the inspection report.
	Supplemental Information Page:
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	OUIN
	serence
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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. If the registration herein applied for is granted, I certify that this business will be conducted in full compliance with all applicable federal and state laws and that I will make available any or all records required by law to the extent authorized by law.

SU

#### Signature of Owner:

I hereby certify that the above Renewal Application to	Operate as a Third	Party Logistics Provider	was
signed, subscribed and sworn to before me this	day of	, 20	
By:			
Signature:			
My Commission Expires	State	of .	











Date:

nine

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 to Operate as a Third Party Logistics Provider

Print legibly. Make check or money order payable to Kentucky State Treasurer or payment can be made online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal. Mail completed notarized application to the above address with required documentation. Incomplete applications will be returned. Licenses expire June 30 following the date of issuance.

J	I. Facility Inform	ation:	SUL		
	Name of Facility:	OUL			
	Physical Address of	Facility:			
	CITY:	STATE:	COUNTY:	ZIP:	
	Mailing Address of I	Facility:			
Ó	CITY:	STATE:	COUNTY:	ZIP:	











Email:		
Phone number:		
Fax Number:		5
Website Address:	70:	
	omplete one of the following: Party Logistics $\rightarrow$ \$400.00	
Proposed date of op		
Dependence of a contract of a	<u>Change</u> → \$150.00 acquisition:	
	owner(s):	
Proposed date of ad Name of previous	equisition:	
Proposed date of ad Name of previous	equisition: owner(s): (Confirmation statement from previous owner must be attached) <u>Address/Location</u> → \$150.00	











## □ <u>Name Change</u> → NO CHARGE

Previous Name:	
II. Registration Numbers a	nd Expiration Dates:
DEA:	Exp. Date:
	iiCo
FDA:	Exp. Date:
V. Name, phone, and email	of the Facility Contact Person:
Name:	
Title:	
Phone Number:	
Email:	
20	
/. Qualifying Questions:	

**1.** Has applicant, or any owner [s], partner [s], officer [s], or agent of the applicant, ever been convicted of any felony under federal, state, and/or local laws?











*If yes: please provide explanation below:	
Explanation:	.*
2. Has applicant, or any owner [s], part	ner [s] officer [s] or agent of the
applicant, ever had a license or perm	
federal, state, or local government?	
□ YES*	
*If yes: please provide explanation below:	<u> </u>
Explanation:	·X.
C.V.	
3. Has applicant, or any owner [s], part	
applicant, ever been convicted under	tederal state and/or local drug laws
including drug samples and wholesal	federal, state and/or local drug laws, e or retail drug distribution of
including drug samples and wholesal controlled substances?	
controlled substances?	e or retail drug distribution of
<pre>controlled substances?</pre>	e or retail drug distribution of
controlled substances?	e or retail drug distribution of
<pre>controlled substances?</pre>	e or retail drug distribution of
<pre>controlled substances?</pre>	e or retail drug distribution of
controlled substances?         YES*         *If yes: please provide explanation below:         Explanation:	e or retail drug distribution of
<pre>controlled substances?</pre>	e or retail drug distribution of











*If yes: please provide license or permit number below

License/Permit No .:

## **VI. Schedule of Hours:**

<u>MONDAY</u>	<u>TUESDAY</u>	WEDNESDAY	<u>THURSDAY</u>	<u>FRIDAY</u>	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
VII. Owne	ership:		- Joh			

## VII. Ownership:

How is the facility registered with the Secretary of State?

- □ Sole Proprietor
- □ Partnership
- □ LLC
- □ Corporation
- $\Box$  Other

 $\star$   $\star$  Please provide the following information for each owner/partner/director/member/officer:

Name: Title	le:











Phone number(Business):		
Phone number(Home):		0
Social Security Number:	Date of Birth:	70,:
Federal Employee ID Number:		icali
Address (Business):	R	<b>2</b> ,
CITY: STATE:	COUNTY:	ZIP:
Address (Home):	Sup	
CITY: STATE:	COUNTY:	ZIP:
Name:	Title:	
Email		
Phone number(Business):		











Social Security Nu	umber:	Date of Birth:	
Federal Employee	D Number:		
Address (Business	3):		Oul
CITY:	STATE:	COUNTY:	ZIP:
Address (Home):			dicat
CITY:	STATE:	COUNTY:	ZIP:
3.		mit	
Name:		Title:	
Email:	214		
Phone number(Bu	siness):		
Phone number(Ho	ome):		
Social Security Nu	umber:	Date of Birth:	
Federal Employee	ID Number:		
Address (Business	5):		











CITY:	STATE:	COUNTY:	ZIP:		
Address (Home)	:				
CITY:	STATE:	COUNTY:	ZIP:		
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Name:		Title:	icali		
Email:			29,		
Phone number(E	Business):	dit t			
Phone number(Home):					
Social Security N	Number:	Date of Birth:			
Federal Employe	ee ID Number:				
Address (Busine	\$5):				
CITY:	STATE:	COUNTY:	ZIP:		
Address (Home)	:				
CITY:	STATE:	COUNTY:	ZIP:		











5.

Email: Phone number(Business): Phone number(Home): Social Security Number: Dat Federal Employee ID Number: Address (Business): CITY: STATE: COUNT Address (Home):	of Birth:
Phone number(Home): Social Security Number: Dat Federal Employee ID Number: Address (Business): CITY: STATE: COUNT	
Social Security Number: Dat Federal Employee ID Number: Address (Business): CITY: STATE: COUNT	
Federal Employee ID Number: Address (Business): CITY: STATE: COUNT	
Address (Business): CITY: STATE: COUNT	700.
CITY: STATE: COUNT	710.
	710.
Address (Home):	ZIP:
CITY: STATE: COUNT	ZIP:
(Use supplemental information p	
ID. List of state, districts, or territorie censed/permitted:	in which











# IX.What was the date of the last facility inspection?

*If perform	ed by an entity other than the Kentucky Board of Pharmacy, please provide
-	a copy of the inspection report.
	Supplemental Information Page:
	NV.
	<b>2</b> *
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Pursuant to KRS 315.121, the Board may refuse to issue or otherwise discipline any licensee or permit holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a permit.

I hereby certify that the foregoing is true and correct to the best of my knowledge. If the license applied for is granted, I certify that this business will be conducted in full compliance with all applicable federal and state laws and that I will make available any or all records required by law to the extent authorized by law.

#### Signature of Owner/Officer and Title:

I hereby certify that the above Application to Operate as a Third Party Logistics Provider was

signed, subscribed and sworn to before me this _____day of _____, 20____.

Signature:

My Commission Expires ____

State	of	











Date:

#### **REQUIRED DOCUMENTATION:**

□ Completed application

Copy of DEA Registration

Copy of Current Inspection Report by FDA, NABP or Board

Copy of FDA Third Party Logistics Registration and other state license (if applicable)

□ Legal proof of name change for Section 2

.ur ur over submit subm Confirmation Statement of former owner for Section 2











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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 License to Operate as Wholesaler

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' and. Mail to the above address. Payment can also be made online at <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal.</u> All applicable entries must be completed. Incomplete applications will be returned. Each license expires September 30th following the date of issuance.

#### I. Facility Information:

	Name of Facility:	OUL			
	Physical Address of	Facility:			
	CITY:	STATE:	COUNTY:	ZIP:	
	Mailing Address of	Facility:			
Ċ	CITY:	STATE:	COUNTY:	ZIP:	
r	Email:				











Fax Number:	
DEA Number:	Exp. Date:
. Check and complete one of the f	ollowing and attach proper fee:
□ <u>New Wholesaler</u> → \$150.00	dice
Proposed date of Opening:	, p.P.Y
(Filed with board 3)	0 days in advance of opening)
□ <u>Change of Ownership</u> → \$150.00	jo _l ,
Proposed date of Acquisition:	
Name of Previous Owner(s):	
	evious owner must be attached)
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	evious owner must be attached)
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	











## $\Box \underline{Name Change} \rightarrow NO CHARGE$

Previous Name:

□ Wholesale Distributor	Virtual Wholesale Distributor
☐ Medical Gas Wholesale Distributor	□ Other Wholesaler: 
	299
V. Name, title, phone and email of t	the facility contact person:
Name:	, <b>0</b> 1,
Title:	
Phone number:	
Email:	
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
Qualifying Questions:	

*If yes: please provide explanation below:











KENTUCKY



Explanation:		

2. Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever had a license or permit related to drugs revoked or suspended by any federal, state, or local government?

□ YES*	
*If yes: please provide explanation below:	
Explanation:	APPIICE

3. Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever been convicted under federal, state and/or local drug laws, including drug samples and wholesale or retail drug distribution of controlled substances?

			□ YES*	S			
	*If ye	»: please prov	ide explanatio	on below:			
	Expl	anation:	O_{ℓ}				
		e C					
	VI. Schedi	ile of Hou	rs:				
	20						
Ċ	<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>
	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:













| CLOSE: |
|--------|--------|--------|--------|--------|--------|--------|
| | | | | | | |

VII. Ownership:

How is the facility registered with the Secretary of State?

- □ Sole Proprietor
- □ Partnership
- \Box LLC
- □ Corporation
- \Box Other

re? online onlin ★ ★ Pursuant to 201 KAR 2:105, Section 4, please provide the following information for each owner/officer/member, including professional designation (e.g. Pres. John Jones, M.D.):

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











CITY:	STATE:	COUNTY:	ZIP:
Address(Busine	ess):		
CITY:	STATE:	COUNTY:	ZIP:
			no _i .
Name:		Title:	icali
Phone number(Business):		29,
Phone number(Home):	dit	
Social Security	Number:	Date of Birth:	
Address(Home)			
CITY:	STATE:	COUNTY:	ZIP:
Address(Busine	ss);		
CITY	STATE:	COUNTY:	ZIP:
Name:		Title:	

KENTUCKY KENTUCKY









Phone number(Home):					
Social Security N	Number:	Date of Birth:	00		
Address(Home):			101		
CITY:	STATE:	COUNTY:	ZIP:		
Address(Busines	s):	, ps	<i>8</i> .		
CITY:	STATE:	COUNTY:	ZIP:		
•		SUN			
Name:	214	Title:			
Phone number(B	Business):				
Phone number(H	lome):				
Social Security N	Number:	Date of Birth:			
Address(Home):					
CITY:	STATE:	COUNTY:	ZIP:		

KENTUCKY KENTUCKY









CITY:	STATE:	COUNTY:	ZIP:	
			C	
Name:		Title:	10:	
Phone number(Bu	isiness):		Calle	
Phone number(Ho	ome):		29 th	
Social Security N	umber:	Date of Birth:		
Address(Home):		SUD		
CITY:	STATE:	COUNTY:	ZIP:	
Address(Business				
CITY:	STATE:	COUNTY:	ZIP:	
		tal information page if necess quivalent pursuar		5,
ection 2.				









IX. Does this facility have a Digital Distributor Accreditation ?

	□ YES*		Ň
*If yes	: please provide the number below		
:			
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		all	
	other states, districts, or ten permitted:	rritories in which	
neenseu/ p	fer mitted.		
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	×		
	CV CV		
	SU		
XI. Has thi	is facility undergone any th	ird-party inspections?	
XI. Has thi			
XI. Has thi	is facility undergone any th	hird-party inspections?	
	YES*		
*If yes: plea	VES *		
*If yes: plea	VES *		
*If yes: plea	VES *		
	VES *		

TEAM KE











tion **REQUIRED DOCUMENTATION FOR NON-RESIDENT FACILITIES MUST BE ENCLOSED:**

 \Box Completed application

□ Copy of Resident Permit/License

□ Copy of Last Inspection Report

□ Copy of DEA Registration

Completed Attached License Verification Form

□ Copy of Surety Bond or other Security

pection R Gubris □ Third-Party Inspection Report (if applicable)













Supplemental Information Page:

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Form 6/2023

TEAM. ÜCKY KENT

The Board may refuse to issue or renew a license, or suspend, temporarily suspend, revoke, fine or reasonably restrict any license holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a license. KRS 315.121.

I hereby certify that the foregoing is true and correct to the best of my knowledge. If the registration herein applied for is granted, I certify that this business will be conducted in full compliance with all applicable federal and state laws and that I will make available any or all records required by law to the extent authorized by law.

SUDI

Signature of Owner/Officer and Title:

I hereby certi	fy that the above Applica	tion for Wholesaler	was signed, subscribed and swo	rn to
	before me this	day of	, 20	
By:	CON .	Biend		
Signature:				
dr	My Commission Exp	pires	State of	













Form 6/2023

Date:

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 License to Operate as Wholesaler

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' and. Mail to the above address. Payment can also be made online at <u>https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal.</u> All applicable entries must be completed. Incomplete applications will be returned. Each license expires September 30th following the date of issuance.

I. Facility Information:

	Name of Facility:	OUL			
	Physical Address of	Facility:			
	CITY:	STATE:	COUNTY:	ZIP:	
	Mailing Address of	Facility:			
Ċ	CITY:	STATE:	COUNTY:	ZIP:	
r	Email:				











Fax Number:	
DEA Number:	Exp. Date:
. Check and complete one of the f	ollowing and attach proper fee:
□ <u>New Wholesaler</u> → \$150.00	dice
Proposed date of Opening:	, p.P.Y
(Filed with board 3)	0 days in advance of opening)
□ <u>Change of Ownership</u> → \$150.00	jo _l ,
Proposed date of Acquisition:	
Name of Previous Owner(s):	
	evious owner must be attached)
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	evious owner must be attached)
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	











$\Box \underline{Name Change} \rightarrow NO CHARGE$

Previous Name:

Wholesale Distributor	Virtual Wholesale Distributor
☐ Medical Gas Wholesale Distributor	□ Other Wholesaler:
	D.P.P.
V. Name, title, phone and email of t	the facility contact person:
Name:	
Title:	
Phone number:	
Email:	
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
Qualifying Questions:	

*If yes: please provide explanation below:











KENTUCKY



Explanation:		

2. Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever had a license or permit related to drugs revoked or suspended by any federal, state, or local government?

□ YES*	
*If yes: please provide explanation below:	
Explanation:	APPIICE

3. Has applicant, or any owner [s], partner [s], officer [s], agent or employee of the applicant, ever been convicted under federal, state and/or local drug laws, including drug samples and wholesale or retail drug distribution of controlled substances?

			□ YES*	S				
	*If yes: please provide explanation below:							
	Explanation:							
	CO O							
	VI. Schedi	ile of Hou	rs:					
	20							
Ċ	<u>MONDAY</u>	<u>TUESDAY</u>	<u>WEDNESDAY</u>	<u>THURSDAY</u>	<u>FRIDAY</u>	<u>SATURDAY</u>	<u>SUNDAY</u>	
	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	













| CLOSE: |
|--------|--------|--------|--------|--------|--------|--------|
|        |        |        |        |        |        |        |

### **VII. Ownership:**

How is the facility registered with the Secretary of State?

- □ Sole Proprietor
- □ Partnership
- $\Box$  LLC
- □ Corporation
- $\Box$  Other

re? online onlin ★ ★ Pursuant to 201 KAR 2:105, Section 4, please provide the following information for each owner/officer/member, including professional designation (e.g. Pres. John Jones, M.D.):

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











CITY:	STATE:	COUNTY:	ZIP:
Address(Busine	ess):		
CITY:	STATE:	COUNTY:	ZIP:
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Name:		Title:	icali
Phone number(	Business):		29,
Phone number(	Home):	dit	•
Social Security	Number:	Date of Birth:	
Address(Home)	·		
CITY:	STATE:	COUNTY:	ZIP:
Address(Busine	ss);		
CITY	STATE:	COUNTY:	ZIP:
Name:		Title:	

KENTUCKY KENTUCKY









Phone number(H	lome):		
Social Security N	Number:	Date of Birth:	00
Address(Home):			101
CITY:	STATE:	COUNTY:	ZIP:
Address(Busines	s):	, ps	<i>8</i> .
CITY:	STATE:	COUNTY:	ZIP:
•		SUN	
Name:	214	Title:	
Phone number(B	Business):		
Phone number(H	lome):		
Social Security N	Number:	Date of Birth:	
Address(Home):			
CITY:	STATE:	COUNTY:	ZIP:

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CITY:	STATE:	COUNTY:	ZIP:
			C
Name:		Title:	· or
Phone number(Bus	iness):		calle
Phone number(Hon	ne):	~	294
Social Security Nur	nber:	Date of Birth:	
Address(Home):		SUDI	
CITY:	STATE:	COUNTY:	ZIP:
Address(Business):	e Oti		
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		al information page if necess <b>quivalent pursuar</b>	ary) <b>It to 201 KAR 2:105</b>
ection 2.	□ YES		









# IX. Does this facility have a Digital Distributor Accreditation ?

	□ YES*		Ň
*If yes	please provide the number below		
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		all	
	other states, districts, or ten permitted:	rritories in which	
neenseu/ p	permitted.		
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	SU		
XI. Has thi	is facility undergone any th	ird-party inspections?	
XI. Has thi			
XI. Has thi	is facility undergone any th	hird-party inspections?	
	VES*		
*If yes: plea	Se include inspection report		
*If yes: plea	Se include inspection report		
*If yes: plea	Se include inspection report		
	Se include inspection report		

TEAM KE











# tion **REQUIRED DOCUMENTATION FOR NON-RESIDENT FACILITIES MUST BE ENCLOSED:**

 $\Box$  Completed application

□ Copy of Resident Permit/License

□ Copy of Last Inspection Report

□ Copy of DEA Registration

Completed Attached License Verification Form

□ Copy of Surety Bond or other Security

pection R Subsection R Subsecti □ Third-Party Inspection Report (if applicable)













# Supplemental Information Page:

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Form 6/2023

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The Board may refuse to issue or renew a license, or suspend, temporarily suspend, revoke, fine or reasonably restrict any license holder for knowingly making or causing to be made, any false, fraudulent or forged statement in connection with an application for a license. KRS 315.121.

I hereby certify that the foregoing is true and correct to the best of my knowledge. If the registration herein applied for is granted, I certify that this business will be conducted in full compliance with all applicable federal and state laws and that I will make available any or all records required by law to the extent authorized by law.

SUDI

#### Signature of Owner/Officer and Title:

I hereby cert	ify that the above Applica	tion for Wholesaler	was signed, subscribed and swo	rn to
	before me this	day of	, 20	
By:		and the		
Signature:				
dr	My Commission Exp	pires	State of	













Form 6/2023

Date: