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.

I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing address of facility:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			

Phone Number:
Fax Number:
Website Address:

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

☐ **New Manufacturer or Virtual Manufacturer → $150.00**

Proposed date of opening:

(Filed with Board 30 days in advance of Opening)

☐ **Change of Ownership → $150.00**

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

(Confirmation statement from previous owner must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Registration Numbers and Expiration Dates:

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

IV. Name, title and email of Facility Contact Person:

Name:	Title:
Email Address:	

V. 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?**

☐ **YES***	☐ **NO**

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*	☐ NO

If yes: please provide explanation below:

Explanation:

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?**

☐ YES*	☐ NO

If yes: please provide explanation below:

Explanation:

VI. Schedule of Hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

VII. Identify the Pharmacist-In-Charge:

Name:	License No.:

201 KAR 2:205 requires pharmacists-in-charge to notify the Board of all personnel changes.

VIII. Ownership:

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

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

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

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

Name:	Title:
Name:	Title:

(Use supplemental information page if necessary)

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

☐ YES*	☐ NO

If yes: please provide a copy of the inspection report

Supplemental Information Page:

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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing address of facility:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			

Phone Number:
Fax Number:
Website Address:

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

☐ **New Manufacturer or Virtual Manufacturer → $150.00**

Proposed date of opening:

(Filed with Board 30 days in advance of Opening)

☐ **Change of Ownership → $150.00**

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

(Confirmation statement from previous owner must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Registration Numbers and Expiration Dates:

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

IV. Name, title and email of Facility Contact Person:

Name:	Title:
Email Address:	

V. 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?**

☐ **YES***	☐ **NO**

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*	☐ NO

If yes: please provide explanation below:

Explanation:

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?**

☐ YES*	☐ NO

If yes: please provide explanation below:

Explanation:

VI. Schedule of Hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

VII. Identify the Pharmacist-In-Charge:

Name:	License No.:

201 KAR 2:205 requires pharmacists-in-charge to notify the Board of all personnel changes.

VIII. Ownership:

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

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

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

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

Name:	Title:
Name:	Title:

(Use supplemental information page if necessary)

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

☐ YES*	☐ NO

If yes: please provide a copy of the inspection report

Supplemental Information Page:

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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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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 https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . 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).

Incomplete applications will be returned.

Type:	☐ **Manufacturer**	☐ **Virtual Manufacturer**

I.Facility Information

License/Permit Number:
Name of Facility:
Physical Address of Facility:

CITY:	STATE:	COUNTY:	ZIP:
Mailing address of facility:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			
Phone Number:			
Fax Number:			
Website Address:			

II. Registration Numbers and Expiration Dates:

DEA Registration No.:	Exp. Date:
FDA Registration No.:	Exp. Date:

III. Name, title and email of Facility Contact Person:

Name:	Title:
Email Address:	

IV. Identify the Pharmacist-in-Charge:

Name:	License No.:

201 KAR 2:205 requires pharmacists-in-charge to notify the Board of all personnel changes.

V. Ownership:

How is this facility registered with the Kentucky Secretary of State?

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

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

☐ **YES***	☐ **NO**

If yes: please provide explanation below:

Explanation:

VII. Schedule of Hours:

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

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.

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: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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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 https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . 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).

Incomplete applications will be returned.

Type:	☐ **Manufacturer**	☐ **Virtual Manufacturer**

I.Facility Information

License/Permit Number:
Name of Facility:
Physical Address of Facility:

CITY:	STATE:	COUNTY:	ZIP:
Mailing address of facility:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			
Phone Number:			
Fax Number:			
Website Address:			

II. Registration Numbers and Expiration Dates:

DEA Registration No.:	Exp. Date:
FDA Registration No.:	Exp. Date:

III. Name, title and email of Facility Contact Person:

Name:	Title:
Email Address:	

IV. Identify the Pharmacist-in-Charge:

Name:	License No.:

201 KAR 2:205 requires pharmacists-in-charge to notify the Board of all personnel changes.

V. Ownership:

How is this facility registered with the Kentucky Secretary of State?

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

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

☐ **YES***	☐ **NO**

If yes: please provide explanation below:

Explanation:

VII. Schedule of Hours:

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

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.

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: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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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 https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing address of facility:			
CITY:	STATE:	COUNTY:	ZIP:

Email:
Phone number:
Fax number:
Website Address:

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

☐ **New Facility** → **$150.00**

Proposed date of opening:

(Filed with board 30 days in advance of opening)

OR Current Permit No. :	Exp. Date:

(In State where presently located)

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

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

(Confirmation statement of previous owner must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change → NO CHARGE**

Previous Name:

III. Ownership:

How is the facility registered with the Secretary of State?

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

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

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

Name:	Title:
Name:	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***	☐ **NO**

If yes: please attach statement

V. Pharmacist in Charge:

Name:	KY License No.:

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

VI. Schedule of Hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
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.)

Supplemental Information Page:

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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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Original Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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Application for Special Limited Pharmacy Permit ⇨ Medical Gas

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I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing address of facility:			
CITY:	STATE:	COUNTY:	ZIP:

Email:
Phone number:
Fax number:
Website Address:

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

☐ **New Facility** → **$150.00**

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(Filed with board 30 days in advance of opening)

OR Current Permit No. :	Exp. Date:

(In State where presently located)

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

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

(Confirmation statement of previous owner must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change → NO CHARGE**

Previous Name:

III. Ownership:

How is the facility registered with the Secretary of State?

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

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

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

Name:	Title:
Name:	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***	☐ **NO**

If yes: please attach statement

V. Pharmacist in Charge:

Name:	KY License No.:

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

VI. Schedule of Hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
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.)

Supplemental Information Page:

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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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Original Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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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 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. 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 Facility:

Kentucky Permit Number:

Address of Facility:

CITY: STATE: COUNTY: ZIP:

Email:

Phone number:
Fax number:
Website Address:

II. Ownership:

How are you registered with the Kentucky Secretary of State?

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

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

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

(Use supplemental information page if necessary)

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.

☐ YES*	☐ NO

*If yes: please attach statement

IV. Pharmacist in Charge:

Name:	KY License No.:

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

V. Schedule of Store Hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
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.)

Supplemental Information Page:

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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].

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Original Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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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 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. 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 Facility:

Kentucky Permit Number:

Address of Facility:

CITY: STATE: COUNTY: ZIP:

Email:

Phone number:
Fax number:
Website Address:

II. Ownership:

How are you registered with the Kentucky Secretary of State?

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

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

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

(Use supplemental information page if necessary)

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.

☐ YES*	☐ NO

If yes: please attach statement

IV. Pharmacist in Charge:

Name:	KY License No.:

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

V. Schedule of Store Hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
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.)

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct to the best of my knowledge and that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the Regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws. [If applicable, this pharmacy is currently licensed and in good standing in all states of licensure].

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Original Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

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 records 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 Date

I hereby certify that the above *Memorandum of Understanding and Agreement* was signed, subscribed and sworn to before me this _____day of _____, 20____

Signature_____

My Commission Expires_____State of _____

_____ _____
Signature of Owner Date

I hereby certify that the above *Memorandum of Understanding and Agreement* was signed, subscribed and sworn to before me this_____day of _____, 20____

Signature_____

My Commission Expires_____State of_____

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

Application for Nonresident Special Limited Pharmacy Permit ⇨ Medical Gas

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing address of facility:			
CITY:	STATE:	COUNTY:	ZIP:

Email:
Phone number:
Fax number:
Website Address:

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

☐ **New Facility → $150.00**

Current Permit No. :	Exp. Date:

(In State where presently located)

☐ **Change of Ownership → $150.00**

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

(Confirmation statement of previous owner must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Ownership:

How is the facility registered with the Secretary of State?

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

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

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

Name:	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*	☐ NO

If yes: please attach statement

V. Pharmacist in Charge:

Name:	KY License No.:

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

VI. Schedule of Hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
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.)

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct to the best of my knowledge, 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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Original Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

Application for Nonresident Special Limited Pharmacy Permit ⇨ Medical Gas

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing address of facility:			
CITY:	STATE:	COUNTY:	ZIP:

Email:
Phone number:
Fax number:
Website Address:

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

☐ **New Facility → $150.00**

Current Permit No. :	Exp. Date:

(In State where presently located)

☐ **Change of Ownership → $150.00**

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

(Confirmation statement of previous owner must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Ownership:

How is the facility registered with the Secretary of State?

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

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

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

Name:	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*	☐ NO

If yes: please attach statement

V. Pharmacist in Charge:

Name:	KY License No.:

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

VI. Schedule of Hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
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.)

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct to the best of my knowledge, 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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Original Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

Application for Nonresident 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 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. 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 Facility:
Kentucky Permit Number:
Address of Facility:
CITY: STATE: COUNTY: ZIP:
Email:

Phone number:
Fax number:
Website Address:

II. Ownership:

How are you registered with the Kentucky Secretary of State?

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

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

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

(Use supplemental information page if necessary)

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.

☐ YES*	☐ NO

*If yes: please attach statement

IV. Pharmacist in Charge:

Name:	KY License No.:

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

V. Schedule of Store Hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
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.)

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct to the best of my knowledge and that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the Regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws. [If applicable, this pharmacy is currently licensed and in good standing in all states of licensure].

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Original Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

Application for Nonresident 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 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. 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 Facility:
Kentucky Permit Number:
Address of Facility:
CITY: STATE: COUNTY: ZIP:
Email:

Phone number:
Fax number:
Website Address:

II. Ownership:

How are you registered with the Kentucky Secretary of State?

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

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

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

(Use supplemental information page if necessary)

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.

☐ YES*	☐ NO

*If yes: please attach statement

IV. Pharmacist in Charge:

Name:	KY License No.:

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

V. Schedule of Store Hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
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.)

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct to the best of my knowledge and that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the Regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws. [If applicable, this pharmacy is currently licensed and in good standing in all states of licensure].

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Original Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

Application For Non-Resident Pharmacy Permit

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Mail completed application to the above address. All applicable entries must be completed. Please use the checklist of required documentation at the end of this application. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Pharmacy Information:

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

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

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

☐ **New Pharmacy → $150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

☐ **Change of Ownership → $150.00**

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

(Must submit documentation detailing the specific ownership changes)

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

Date of Proposed Relocation:

Previous Address:			
CITY:	STATE:	COUNTY:	ZIP:

☐ **Name Change → NO CHARGE**

Previous Name:

III. Ownership:

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

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ Not Applicable

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

1.

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

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

2.

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

3.

Name:	Title:

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

4.

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

5.

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

(Use supplemental information page if necessary)

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

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

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

Name: License No. :

Name: License No. :

Name: License No. :

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

(Use supplemental information page if necessary)

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

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

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

(Use supplemental information page if necessary)

VI. Schedule of Hours:

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

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

CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

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

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

☐ YES*	☐ NO

If yes: identify the source for:

Hardware: _____

Software: _____

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

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

*This must be checked if the pharmacy dispenses any prescriptions to citizens of the Commonwealth of Kentucky, in whole or in part, via the Internet [agent, internet broker or shipper]. If Internet is checked, Section 9 must be completed.

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

☐ YES	☐ NO

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

☐ YES*	☐ NO

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

:

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

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

2.Name:

Address:

CITY: STATE: COUNTY: ZIP:

Email Address:

Phone Number:

3.Name:

Address:

CITY: STATE: COUNTY: ZIP:

Email Address:

Phone Number:

4.Name:

Address:

CITY: STATE: COUNTY: ZIP:

Email Address:

Phone Number:

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

(Use supplemental information page if necessary)

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

☐ **YES***	☐ **NO**

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

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

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

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

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

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

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

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

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

(Use supplemental information page if necessary)

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

☐ **YES***	☐ **NO**

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

(Use supplemental information page if necessary)

XIII. List the methods of deliver services (e.g. USPS, UPS, FedEx, etc) utilized to deliver prescriptions to citizens of the Commonwealth of

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

Delivery Service Utilized:	Percentage of Time:

(Use supplemental information page if necessary)

XIV. Are you permitted in other states?

☐ YES*	☐ NO

If yes: please list below

:

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

☐ YES*	☐ NO

If yes: please attach statement

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

☐ YES	☐ NO

XVII. Do you perform sterile compounding?

☐ YES	☐ NO

XVIII. Do you perform nonsterile compounding?

☐ YES	☐ NO

XIX. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

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

☐ YES	☐ NO

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

☐ YES	☐ NO

XXII. Date of last controlled substance inventory:

Date:

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct and that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

REQUIRED DOCUMENTATION MUST BE ENCLOSED:

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

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

Application For Non-Resident Pharmacy Permit

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Mail completed application to the above address. All applicable entries must be completed. Please use the checklist of required documentation at the end of this application. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Pharmacy Information:

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

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

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

☐ **New Pharmacy → $150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

☐ **Change of Ownership → $150.00**

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

(Must submit documentation detailing the specific ownership changes)

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

Date of Proposed Relocation:

Previous Address:			
CITY:	STATE:	COUNTY:	ZIP:

☐ **Name Change → NO CHARGE**

Previous Name:

III. Ownership:

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

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ Not Applicable

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

1.

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

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

2.

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

3.

Name:	Title:

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

4.

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

5.

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

(Use supplemental information page if necessary)

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

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

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

Name: License No. :

Name: License No. :

Name: License No. :

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

(Use supplemental information page if necessary)

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

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

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

(Use supplemental information page if necessary)

VI. Schedule of Hours:

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

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

CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

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

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

☐ YES*	☐ NO

If yes: identify the source for:

Hardware: _____

Software: _____

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

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

*This must be checked if the pharmacy dispenses any prescriptions to citizens of the Commonwealth of Kentucky, in whole or in part, via the Internet [agent, internet broker or shipper]. If Internet is checked, Section 9 must be completed.

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

☐ YES	☐ NO

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

☐ YES*	☐ NO

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

:

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

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

2.Name:

Address:

CITY: STATE: COUNTY: ZIP:

Email Address:

Phone Number:

3.Name:

Address:

CITY: STATE: COUNTY: ZIP:

Email Address:

Phone Number:

4.Name:

Address:

CITY: STATE: COUNTY: ZIP:

Email Address:

Phone Number:

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

(Use supplemental information page if necessary)

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

☐ **YES***	☐ **NO**

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

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

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

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

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

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

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

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

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

(Use supplemental information page if necessary)

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

☐ **YES***	☐ **NO**

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

(Use supplemental information page if necessary)

XIII. List the methods of deliver services (e.g. USPS, UPS, FedEx, etc) utilized to deliver prescriptions to citizens of the Commonwealth of

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

Delivery Service Utilized:	Percentage of Time:

(Use supplemental information page if necessary)

XIV. Are you permitted in other states?

☐ YES*	☐ NO

If yes: please list below

:

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

☐ YES*	☐ NO

If yes: please attach statement

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

☐ YES	☐ NO

XVII. Do you perform sterile compounding?

☐ YES	☐ NO

XVIII. Do you perform nonsterile compounding?

☐ YES	☐ NO

XIX. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

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

☐ YES	☐ NO

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

☐ YES	☐ NO

XXII. Date of last controlled substance inventory:

Date:

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct and that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

REQUIRED DOCUMENTATION MUST BE ENCLOSED:

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

KENTUCKY 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 Information:

Name of Facility:
Kentucky Permit No.:
Physical Address of Facility:
CITY: STATE: COUNTY: ZIP:
Email Address:

Phone Number:
Fax Number:
Website Address:

II. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

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*	☐ NO

If yes: Please explain below

:

IV. Pharmacist in Charge (P.I.C.), Pharmacist(s), Interns and Technicians:

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

(Use supplemental information page if necessary)

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

V. Schedule of Hours:

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

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

★Please indicate if closed for lunch:

_____ until _____

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct to the best of my knowledge, 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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

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 Information:

Name of Facility:
Kentucky Permit No.:
Physical Address of Facility:
CITY: STATE: COUNTY: ZIP:
Email Address:

Phone Number:
Fax Number:
Website Address:

II. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

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*	☐ NO

If yes: Please explain below

:

IV. Pharmacist in Charge (P.I.C.), Pharmacist(s), Interns and Technicians:

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

(Use supplemental information page if necessary)

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

V. Schedule of Hours:

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

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

★Please indicate if closed for lunch:

_____ until _____

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct to the best of my knowledge, 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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

Application for Non-Resident 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 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.

I. Facility Information:

Name of Facility:
Kentucky Permit No.:
Physical Address of Facility:
CITY: STATE: COUNTY: ZIP:
Email Address:
Phone Number:
Fax Number:

Website Address:

II. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

III. Schedule of Hours:

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

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS

★Please indicate if closed for lunch:

_____ until _____

EMPLOYEE INFORMATION:

1. Pharmacist in Charge (P.I.C.):

Name:	License No.:

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

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

Name:	License/Registration Number (Pharmacist, Pharmacist Intern or Pharmacy Technician):
1.	
2.	
3.	
4.	

5.	
6.	
7.	
8.	
9.	
10.	

(Use supplemental information page if necessary)

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

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

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

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

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

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

(Use supplemental information page if necessary)

IV. Discipline:

Have you had a Pharmacy license/permit disciplined by any agency which you have not previously reported to this Board?

☐ **YES***	☐ **NO**

If yes: Please explain below

:

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*	☐ NO

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

(Use supplemental information page if necessary)

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

Delivery Service Utilized: **Percentage of Time:**

(Use supplemental information page if necessary)

VII. Are you permitted in other states?

☐ YES*	☐ NO

If yes: please list below

:

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct to the best of my knowledge, 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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Original Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Form 9/2023

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 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.

I. Facility Information:

Name of Facility:
Kentucky Permit No.:
Physical Address of Facility:
CITY: STATE: COUNTY: ZIP:
Email Address:
Phone Number:
Fax Number:

Website Address:

II. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

III. Schedule of Hours:

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

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS

★Please indicate if closed for lunch:

_____ until _____

EMPLOYEE INFORMATION:

1. Pharmacist in Charge (P.I.C.):

Name:	License No.:

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

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

Name:	License/Registration Number (Pharmacist, Pharmacist Intern or Pharmacy Technician):
1.	
2.	
3.	
4.	

5.	
6.	
7.	
8.	
9.	
10.	

(Use supplemental information page if necessary)

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

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

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

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

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

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

(Use supplemental information page if necessary)

IV. Discipline:

Have you had a Pharmacy license/permit disciplined by any agency which you have not previously reported to this Board?

☐ **YES***	☐ **NO**

If yes: Please explain below

:

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*	☐ NO

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

(Use supplemental information page if necessary)

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

Delivery Service Utilized: **Percentage of Time:**

(Use supplemental information page if necessary)

VII. Are you permitted in other states?

☐ YES*	☐ NO

If yes: please list below

:

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct to the best of my knowledge, 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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Original Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Form 9/2023

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

Application for Non-Resident Special Limited Pharmacy Permit ⇨ Charitable Pharmacy

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:

Email Address:
Phone Number:
Fax Number:
Website Address:

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

☐ **New Facility** → **$150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

OR Current Permit No. : Exp. Date:

(In State where presently located)

☐ **Change of Ownership** → **$0**

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

(Confirmation statement of previous must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change → $0**

Previous Name:

III. Ownership:

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

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

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

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

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

Name:		Title:	
Address (Home):			
CITY:	STATE:	COUNTY:	ZIP:
Address (Business):			
CITY:	STATE:	COUNTY:	ZIP:
Phone Number(Home):			
Phone Number(Business):			

Date of Birth:
Social Security Number:

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

Name:	Title:
Address (Home):	

CITY:	STATE:	COUNTY:	ZIP:

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

Phone Number(Home):

Phone Number(Business):

Date of Birth:

Social Security Number:

Name:	Title:

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

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

Phone Number(Home):

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

(Use supplemental information page if necessary)

IV. Pharmacist in Charge:

Name:	KY License No.:

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

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

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

(Use supplemental information page if necessary)

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

Name:	Title:

Name:	Title:

Name:	Title:

Name:	Title:

Name:	Title:

(Use supplemental information page if necessary)

VII. Schedule of Hours:

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

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

★Please indicate if closed for lunch:

_____ until _____

VIII. Discipline:

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

☐ YES*	☐ NO

If yes: Please explain below

:

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

☐ YES*	☐ NO

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

(Use supplemental information page if necessary)

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

Delivery Service Utilized:	Percentage of Time:

(Use supplemental information page if necessary)

XI. Are you permitted in other states?

☐ YES*	☐ NO

If yes: please list below

:

Supplemental Information Page:

REQUIRED DOCUMENTATION MUST BE ENCLOSED:

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

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

I hereby certify that the foregoing is true and correct to the best of my knowledge, that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws, and that the facility is currently licensed and in good standing in all states of licensure DATE.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

Application for Non-Resident Special Limited Pharmacy Permit ⇨ Charitable Pharmacy

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:

Email Address:
Phone Number:
Fax Number:
Website Address:

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

☐ **New Facility** → **$150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

OR Current Permit No. :	Exp. Date:

(In State where presently located)

☐ **Change of Ownership** → **$0**

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

(Confirmation statement of previous must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change → $0**

Previous Name:

III. Ownership:

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

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

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

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

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

Name:		Title:	
Address (Home):			
CITY:	STATE:	COUNTY:	ZIP:
Address (Business):			
CITY:	STATE:	COUNTY:	ZIP:
Phone Number(Home):			
Phone Number(Business):			

Date of Birth:
Social Security Number:

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

Name:	Title:
Address (Home):	

CITY:	STATE:	COUNTY:	ZIP:

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

Phone Number(Home):

Phone Number(Business):

Date of Birth:

Social Security Number:

Name:	Title:

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

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

Phone Number(Home):

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

(Use supplemental information page if necessary)

IV. Pharmacist in Charge:

Name:	KY License No.:

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

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

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

(Use supplemental information page if necessary)

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

Name:	Title:

Name:	Title:

Name:	Title:

Name:	Title:

Name:	Title:

(Use supplemental information page if necessary)

VII. Schedule of Hours:

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

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

★Please indicate if closed for lunch:

_____ until _____

VIII. Discipline:

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

☐ YES*	☐ NO

If yes: Please explain below

:

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

☐ YES*	☐ NO

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

(Use supplemental information page if necessary)

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

Delivery Service Utilized:	Percentage of Time:

(Use supplemental information page if necessary)

XI. Are you permitted in other states?

☐ YES*	☐ NO

If yes: please list below

:

Supplemental Information Page:

REQUIRED DOCUMENTATION MUST BE ENCLOSED:

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

NON-RESIDENT PHARMACY PERMIT VERIFICATION

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		
Physical Address of Pharmacy		
City	State	ZIP Code
Name of Pharmacist-in-Charge	License Number	

The following section is to be completed by the Board of Pharmacy of the state in which the applicant 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 licensing jurisdiction, government agency, law enforcement agency or court? ☐ Yes* ☐ No

***If yes, attach a letter of explanation, a copy of the charging document/complaint and all relevant court documents.**

Has the Pharmacist-in-Charge been the subject of disciplinary action(s) taken by any licensing jurisdiction, government agency, law enforcement agency or court? ☐ Yes* ☐ No

***If yes, attach a letter of explanation, a copy of the charging document/complaint and all relevant court documents.**

Printed name and title of State Official	State
Signature of State Official	Date

SEAL

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.

I. Facility Information:

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

Phone Number:
Fax Number:
Website Address:

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

☐ **New Facility** → **$150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

OR Current Permit No. :	Exp. Date:

(In State where presently located)

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

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

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

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

Date of Proposed Relocation:

Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

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

☐ YES*	☐ NO

If yes: Please explain below

:

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

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

(Use supplemental information page if necessary)

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:

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

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

★Please indicate if closed for lunch:

_____ until _____

Supplemental Information Page:

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Form 9/2023

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.

I. Facility Information:

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

Phone Number:
Fax Number:
Website Address:

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

☐ **New Facility** → **$150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

OR Current Permit No. :	Exp. Date:

(In State where presently located)

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

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

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

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

Date of Proposed Relocation:

Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

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

☐ YES*	☐ NO

If yes: Please explain below

:

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

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

(Use supplemental information page if necessary)

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:

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

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

★Please indicate if closed for lunch:

_____ until _____

Supplemental Information Page:

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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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Form 9/2023

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

Application For Non-Resident Pharmacy Permit Renewal

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

I. Pharmacy Information:

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

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

II. Ownership:

How are you registered with the Kentucky Secretary of State?

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ Not Applicable

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

1.

Name:	Title:

2.

Name:	Title:

3.

Name:	Title:

4.

Name:	Title:

5.

Name:	Title:

(Use supplemental information page if necessary)

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

P.I.C. :	KY License No.:
City of Residence:	

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

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

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

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary)

V. Schedule of Hours:

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

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

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

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

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

Name: License No. :

(Use supplemental information page if necessary)

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

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

*This must be checked if the pharmacy dispenses any prescriptions to citizens of the Commonwealth of Kentucky, in whole or in part, via the Internet [agent, internet broker or shipper]. If Internet is checked, digital pharmacy accreditation will be verified with the NABP and Section 8 must be completed.

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

☐ **YES***	☐ **NO**

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

:

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

1.Name:

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

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

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

Phone Number:

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

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

(Use supplemental information page if necessary)

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

☐ YES*	☐ NO

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

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

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

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

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

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

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

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

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

(Use supplemental information page if necessary)

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

☐ YES*	☐ NO

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

(Use supplemental information page if necessary)

XI. Do you perform sterile compounding?

☐ YES	☐ NO

XII. Do you perform non-sterile compounding?

☐ YES	☐ NO

XIII. Are you permitted in other states?

☐ YES*	☐ NO

If yes: Please list below

:

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

☐ **YES***	☐ **NO**

If yes: Please explain below

:

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

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

(Use supplemental information page if necessary)

XVI. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

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

☐ YES	☐ NO

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

☐ YES*	☐ NO

If yes: Please explain below

:

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct and that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws.

Signature of Pharmacist-In-Charge: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

Application For Non-Resident Pharmacy Permit Renewal

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

I. Pharmacy Information:

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

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

II. Ownership:

How are you registered with the Kentucky Secretary of State?

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ LLC
- ☐ Corporation
- ☐ Not Applicable

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

1.

Name:	Title:

2.

Name:	Title:

3.

Name:	Title:

4.

Name:	Title:

5.

Name:	Title:

(Use supplemental information page if necessary)

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

P.I.C. :	KY License No.:
City of Residence:	

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

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

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

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary)

V. Schedule of Hours:

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

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

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

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

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

Name: License No. :

(Use supplemental information page if necessary)

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

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

*This must be checked if the pharmacy dispenses any prescriptions to citizens of the Commonwealth of Kentucky, in whole or in part, via the Internet [agent, internet broker or shipper]. If Internet is checked, digital pharmacy accreditation will be verified with the NABP and Section 8 must be completed.

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☐ **YES***	☐ **NO**

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

: _____

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

1.Name:

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

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

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

Phone Number:

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

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

(Use supplemental information page if necessary)

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

☐ YES*	☐ NO

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

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

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

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

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

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

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

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

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

(Use supplemental information page if necessary)

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

☐ YES*	☐ NO

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

(Use supplemental information page if necessary)

XI. Do you perform sterile compounding?

☐ YES	☐ NO

XII. Do you perform non-sterile compounding?

☐ YES	☐ NO

XIII. Are you permitted in other states?

☐ YES*	☐ NO

If yes: Please list below

:

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

☐ **YES***	☐ **NO**

If yes: Please explain below

:

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

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

(Use supplemental information page if necessary)

XVI. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

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

☐ YES	☐ NO

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

☐ YES*	☐ NO

If yes: Please explain below

:

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct and that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws.

Signature of Pharmacist-In-Charge: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

Application For Resident Pharmacy Renewal

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

INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED

I. Pharmacy Information:

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

Phone Number:	
Fax Number:	
Website Address:	
Date of last controlled substance inventory:	
DEA Registration No.:	Exp. Date:

II. Ownership:

How are you registered with the Kentucky Secretary of State?

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

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

1.

Name:	Title:

2.

Name:	Title:

3.

Name:	Title:

4.

Name:	Title:

5.

Name:	Title:

(Use supplemental information page if necessary)

III. Schedule of Hours:

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

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS

★Please indicate if closed for lunch:

_____ until _____

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

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

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

V. Does pharmacy ship medications outside of Kentucky?

☐ **YES**	☐ **NO**

VI. Do you perform sterile compounding?

☐ **YES**	☐ **NO**

VII. Do you perform non-sterile compounding?

☐ **YES**	☐ **NO**

VIII. Are you permitted in other states?

☐ **YES**	☐ **NO**

If yes: Please list below

:

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

☐ YES*	☐ NO

If yes: Please explain below

:

X. For institutional pharmacies, are there decentralized pharmacy services (i.e. oncology satellite, OR satellite, etc.) where drugs are prepared, stored, and/or compounded in the facility?

☐ YES*	☐ NO

If yes: how many?

:

XI. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

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

☐ YES	☐ NO

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

☐ YES*	☐ NO

If yes: Please explain below

:

EMPLOYEE INFORMATION:

1. Pharmacist-In-Charge (PIC):

Name:	KY License Number:

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

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

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

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

(Use supplemental information page if necessary)

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

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

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

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

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

(Use supplemental information page if necessary)

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

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

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

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

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct and that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws.

Signature of Owner: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

Application For Resident Pharmacy Renewal

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

INCOMPLETE OR UNSIGNED APPLICATIONS WILL BE RETURNED

I. Pharmacy Information:

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

Phone Number:	
Fax Number:	
Website Address:	
Date of last controlled substance inventory:	
DEA Registration No.:	Exp. Date:

II. Ownership:

How are you registered with the Kentucky Secretary of State?

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

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

1.

Name:	Title:

2.

Name:	Title:

3.

Name:	Title:

4.

Name:	Title:

5.

Name:	Title:

(Use supplemental information page if necessary)

III. Schedule of Hours:

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

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS

★Please indicate if closed for lunch:

_____ until _____

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

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

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

V. Does pharmacy ship medications outside of Kentucky?

☐ **YES**	☐ **NO**

VI. Do you perform sterile compounding?

☐ **YES**	☐ **NO**

VII. Do you perform non-sterile compounding?

☐ **YES**	☐ **NO**

VIII. Are you permitted in other states?

☐ **YES**	☐ **NO**

If yes: Please list below

:

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☐ YES*	☐ NO

If yes: Please explain below

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X. For institutional pharmacies, are there decentralized pharmacy services (i.e. oncology satellite, OR satellite, etc.) where drugs are prepared, stored, and/or compounded in the facility?

☐ YES*	☐ NO

If yes: how many?

:

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☐ YES	☐ NO

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☐ YES	☐ NO

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

☐ YES*	☐ NO

If yes: Please explain below

:

EMPLOYEE INFORMATION:

1. Pharmacist-In-Charge (PIC):

Name:	KY License Number:

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

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

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

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

(Use supplemental information page if necessary)

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

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

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

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

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

(Use supplemental information page if necessary)

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

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

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

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

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct and that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws.

Signature of Owner: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

KENTUCKY BOARD OF PHARMACY
State Office Building Annex,Suite 300
125 Holmes Street
Frankfort KY 40601
Phone: (502) 564-7910
Fax: (502) 696-3806
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:
Kentucky Permit No.:
Physical Address of Facility:
CITY: STATE: COUNTY: ZIP:
Email Address:

Phone Number:
Fax Number:
Website Address:

II. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

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*	☐ NO

If yes: Please explain below

:

IV. Pharmacist in Charge (P.I.C.), Pharmacist(s), Interns and Technicians:

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

(Use supplemental information page if necessary)

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

V. Schedule of Hours:

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

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

★Please indicate if closed for lunch:

_____ until _____

Supplemental Information Page:

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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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

Application for 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:
Kentucky Permit No.:
Physical Address of Facility:
CITY: STATE: COUNTY: ZIP:
Email Address:

Phone Number:
Fax Number:
Website Address:

II. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

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*	☐ NO

If yes: Please explain below

:

IV. Pharmacist in Charge (P.I.C.), Pharmacist(s), Interns and Technicians:

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

(Use supplemental information page if necessary)

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

V. Schedule of Hours:

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

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

★Please indicate if closed for lunch:

_____ until _____

Supplemental Information Page:

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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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

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.

Type:

☐ **Wholesale Distributor**	☐ **Virtual Wholesale Distributor**
☐ **Medical Gas Wholesale Distributor**	☐ **Other:** _____.

I. Facility Information:

Name of Facility:
License Number:

Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Email:			
Phone number:			
Fax number:			
DEA Registration No.:		Exp. Date:	

II. Name, title, phone and email of the facility contact person:

Name:
Title:
Phone number:
Email:

III. Ownership:

How is the facility registered with the Secretary of State?

☐ Sole Proprietor

☐ Partnership
☐ LLC
☐ Corporation
☐ Other

★★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.

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

2.

Name:	Title:

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

3.

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

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

4.

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

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

5.

Name:	Title:
Phone number(Business):	

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

(Use supplemental information page if necessary)

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***	☐ **NO**

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?**

☐ YES*	☐ NO

*If yes: please provide explanation below:

Explanation:

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*	☐ NO

*If yes: please provide explanation below:

Explanation:

V. Schedule of Hours:

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

VI. Does this facility have a Digital Distributor Accreditation?

☐ YES	☐ NO

VII. List of other states, districts, or territories in which licensed/permitted:

:

VIII. Has this facility undergone any third-party inspections?

☐ YES*	☐ NO

If yes: please include inspection report

Supplemental Information Page:

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: _____ **Date:** _____

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 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.

Type:

☐ **Wholesale Distributor**	☐ **Virtual Wholesale Distributor**
☐ **Medical Gas Wholesale Distributor**	☐ **Other:** _____.

I. Facility Information:

Name of Facility:
License Number:

Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Email:			
Phone number:			
Fax number:			
DEA Registration No.:		Exp. Date:	

II. Name, title, phone and email of the facility contact person:

Name:
Title:
Phone number:
Email:

III. Ownership:

How is the facility registered with the Secretary of State?

☐ Sole Proprietor

☐ Partnership
☐ LLC
☐ Corporation
☐ Other

★★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.

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

2.

Name:	Title:

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

3.

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

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

4.

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

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

5.

Name:	Title:
Phone number(Business):	

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

(Use supplemental information page if necessary)

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***	☐ **NO**

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?**

☐ YES*	☐ NO

*If yes: please provide explanation below:

Explanation:

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*	☐ NO

*If yes: please provide explanation below:

Explanation:

V. Schedule of Hours:

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

VI. Does this facility have a Digital Distributor Accreditation?

☐ YES	☐ NO

VII. List of other states, districts, or territories in which licensed/permitted:

:

VIII. Has this facility undergone any third-party inspections?

☐ YES*	☐ NO

If yes: please include inspection report

Supplemental Information Page:

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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: _____ **Date:** _____

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

Application For Permit To Operate A Pharmacy In Kentucky

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal
Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Pharmacy Information:

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

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

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

☐ **New Facility** → **$150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

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

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

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

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Ownership:

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

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

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

1.

Name:	Title:

2.

Name:	Title:

3.

Name:	Title:

4.

Name:	Title:

5.

Name:	Title:

(Use supplemental information page if necessary)

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

☐ **YES***	☐ **NO**

If yes: Please explain below

:

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

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

		☐	☐
		☐	☐

(Use supplemental information page if necessary)

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

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

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

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

(Use supplemental information page if necessary)

VII. Schedule of Hours:

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

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

CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

★Please indicate if closed for lunch:

_____ until _____

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

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

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

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary)

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

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

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

☐ YES*	☐ NO

***If yes:** identify the source for:

Hardware: _____

Software: _____

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

☐ YES	☐ NO

XII. Do you plan on performing sterile compounding?

☐ YES	☐ NO

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

☐ YES	☐ NO

XIV. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

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

☐ YES	☐ NO

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

☐ YES	☐ NO

Supplemental Information Page:

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I hereby certify that the foregoing is true and correct to the best of my knowledge and that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

Application For Permit To Operate A Pharmacy In Kentucky

Please print legibly. Make check or money order payable to 'Kentucky State Treasurer' Treasurer' or pay online at https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal
Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Pharmacy Information:

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

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

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

☐ **New Facility → $150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

☐ **Change of Ownership → $150.00**

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

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

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Ownership:

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

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

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

1.

Name:	Title:

2.

Name:	Title:

3.

Name:	Title:

4.

Name:	Title:

5.

Name:	Title:

(Use supplemental information page if necessary)

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

☐ **YES***	☐ **NO**

If yes: Please explain below

:

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

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

		☐	☐
		☐	☐

(Use supplemental information page if necessary)

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

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

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

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

(Use supplemental information page if necessary)

VII. Schedule of Hours:

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

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

CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

★Please indicate if closed for lunch:

_____ until _____

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

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

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

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Affiliation:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary)

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

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

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

☐ YES*	☐ NO

***If yes:** identify the source for:

Hardware: _____

Software: _____

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

☐ YES	☐ NO

XII. Do you plan on performing sterile compounding?

☐ YES	☐ NO

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

☐ YES	☐ NO

XIV. Does this pharmacy stock any emergency medication kits?

☐ YES	☐ NO

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

☐ YES	☐ NO

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

☐ YES	☐ NO

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct to the best of my knowledge and that I have read and understand Kentucky Revised Statutes Chapters 217, 218A, and 315 and the regulations of the Kentucky Board of Pharmacy and the Cabinet for Health and Family Services pertaining to the practice of pharmacy and certify that this pharmacy will be conducted in full compliance with all federal and state laws.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

I. Facility Information:

Name of Facility:
Kentucky Permit No.:
Physical Address of Facility:
CITY: STATE: COUNTY: ZIP:
Email Address:
Phone Number:
Fax Number:

Website Address:

II. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

III. Schedule of Hours:

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

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS

★Please indicate if closed for lunch:

_____ until _____

EMPLOYEE INFORMATION:

1. Pharmacist in Charge (P.I.C.):

Name:	License No.:

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

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

Name:	License/Registration Number (Pharmacist, Pharmacist Intern or Pharmacy Technician):
1.	
2.	
3.	
4.	

5.	
6.	
7.	
8.	
9.	
10.	

(Use supplemental information page if necessary)

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

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

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

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary)

4. 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***	☐ **NO**

If yes: Please explain below

:

Supplemental Information Page:

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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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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 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.

I. Facility Information:

Name of Facility:
Kentucky Permit No.:
Physical Address of Facility:
CITY: STATE: COUNTY: ZIP:
Email Address:
Phone Number:
Fax Number:

Website Address:

II. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

III. Schedule of Hours:

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

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:	OPEN:
CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:
☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS	☐ 24 HOURS

★Please indicate if closed for lunch:

_____ until _____

EMPLOYEE INFORMATION:

1. Pharmacist in Charge (P.I.C.):

Name:	License No.:

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

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

Name:	License/Registration Number (Pharmacist, Pharmacist Intern or Pharmacy Technician):
1.	
2.	
3.	
4.	

5.	
6.	
7.	
8.	
9.	
10.	

(Use supplemental information page if necessary)

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

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

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

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

Name:	Title:

Address:			
CITY:	STATE:	COUNTY:	ZIP:

(Use supplemental information page if necessary)

4. 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***	☐ **NO**

If yes: Please explain below

:

Supplemental Information Page:

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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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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 https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal . Mail to the above address. All applicable entries must be completed. Incomplete applications will be returned. Each permit expires June 30th following the date of issuance.

I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:

Email Address:
Phone Number:
Fax number:
Website Address:

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

☐ **New Facility** → **$150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

OR Current Permit No. : Exp. Date:

(In State where presently located)

☐ **Change of Ownership** → **$0**

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

(Confirmation statement of previous must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change → $0**

Previous Name:

III. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

IV. Pharmacist in Charge:

Name:	KY License No.:

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

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

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

(Use supplemental information page if necessary)

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

Name:	Title:
Name:	Title:

Name:	Title:

Name:	Title:

Name:	Title:

(Use supplemental information page if necessary)

VII. Schedule of Hours:

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

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

★Please indicate if closed for lunch:

_____ until _____

VIII. Discipline:

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

☐ YES*	☐ NO

If yes: Please explain below

:

Supplemental Information Page:

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

KENTUCKY BOARD OF PHARMACY
State Office Building Annex,Suite 300
125 Holmes Street
Frankfort KY 40601
Phone:(502) 564-7910
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Application for Resident Special Limited Pharmacy Permit ⇨ Charitable Pharmacy

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Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:

Email Address:
Phone Number:
Fax number:
Website Address:

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

☐ **New Facility** → **$150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

OR Current Permit No. : Exp. Date:

(In State where presently located)

☐ **Change of Ownership** → **$0**

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

(Confirmation statement of previous must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change → $0**

Previous Name:

III. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

IV. Pharmacist in Charge:

Name:	KY License No.:

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

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

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

(Use supplemental information page if necessary)

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

Name:	Title:
Name:	Title:

Name:	Title:

Name:	Title:

Name:	Title:

(Use supplemental information page if necessary)

VII. Schedule of Hours:

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

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

★Please indicate if closed for lunch:

_____ until _____

VIII. Discipline:

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

☐ **YES***	☐ **NO**

If yes: Please explain below

:

Supplemental Information Page:

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

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.

I. Facility Information:

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

Phone Number:
Fax Number:
Website Address:

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

☐ **New Facility** → **$150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

OR Current Permit No. :	Exp. Date:

(In State where presently located)

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

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

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

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

Date of Proposed Relocation:

Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

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

☐ YES*	☐ NO

If yes: Please explain below

:

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

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

(Use supplemental information page if necessary)

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:

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

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

★Please indicate if closed for lunch:

_____ until _____

Supplemental Information Page:

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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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Form 6/2023

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

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Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Email Address:			

Phone Number:
Fax Number:
Website Address:

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

☐ **New Facility** → **$150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

OR Current Permit No. :	Exp. Date:

(In State where presently located)

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

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

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

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

Date of Proposed Relocation:

Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Ownership:

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

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

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

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

(Use supplemental information page if necessary)

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

☐ YES*	☐ NO

If yes: Please explain below

:

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

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

(Use supplemental information page if necessary)

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:

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

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

★Please indicate if closed for lunch:

_____ until _____

Supplemental Information Page:

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

I hereby certify that the foregoing is true and correct to the best of my knowledge, 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.

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

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Signature of Owner: **Date:**

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

By: _____

Signature: _____

My Commission Expires _____ State of _____.

Form 6/2023

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.

I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:

Email:
Phone number:
Fax Number:
Website Address:

II. Check and complete one of the following:

☐ **New Third Party Logistics → $400.00**

Proposed date of opening:

☐ **Ownership Change → $150.00**

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

(Confirmation statement from previous owner must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change → NO CHARGE**

Previous Name:

III. Registration Numbers and Expiration Dates:

DEA:	Exp. Date:

FDA:	Exp. Date:

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

Name:
Title:
Phone Number:
Email:

V. 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?**

☐ YES*	☐ NO

If yes: please provide explanation below:

Explanation:

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

☐ YES*	☐ NO

If yes: please provide explanation below:

Explanation:

3. **Has applicant, or any owner [s], partner [s], officer [s], or agent 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*	☐ NO

If yes: please provide explanation below:

Explanation:

4. **Has applicant, officer, partner or director ever applied for a license with this Board?**

☐ YES*	☐ NO

*If yes: please provide license or permit number below

License/Permit No.:

VI. Schedule of Hours:

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

VII. Ownership:

How is the facility registered with the Secretary of State?

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

★★ Please provide the following information for each owner/partner/director/member/officer:

1.

Name:	Title:

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

2.

Name:	Title:
Email:	
Phone number(Business):	
Phone number(Home):	

Social Security Number:	Date of Birth:
Federal Employee ID Number:	
Address (Business):	
CITY: STATE: COUNTY: ZIP:	
Address (Home):	
CITY: STATE: COUNTY: ZIP:	

3.

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

CITY:	STATE:	COUNTY:	ZIP:

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

4.

Name:	Title:

Email:

Phone number(Business):

Phone number(Home):

Social Security Number:	Date of Birth:

Federal Employee ID Number:

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

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

5.

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

(Use supplemental information page if necessary)

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

:

IX.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:

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: _____ **Date:** _____

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_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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

☐ Confirmation Statement of former owner for Section 2

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

Application 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 Information:

Facility Name:			
Address:			
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
- ☐ LLC
- ☐ Corporation
- ☐ Other

★★ Please provide the following information for each owner/partner/director/member/officer:

1.

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

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

2.

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

3.

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

5.

Name:	Title:
Email:	
Phone number(Business):	
Phone number(Home):	
Social Security Number:	Date of Birth:
Federal Employee ID Number:	

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

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

(Use supplemental information page if necessary)

III. Schedule of Hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
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:

Name:
Title:
Phone Number:
Email:

VI. Qualifying Questions:

1. **Have any owner [s], partner [s], officer [s], or agent been convicted of any felony under federal, state, and/or local laws that has not been previously reported to the Board?**

☐ **YES***	☐ **NO**

If yes: please provide explanation below:

Explanation:

2. **Has any owner [s], partner [s], officer [s] or agent had a license or permit related to drugs disciplined by any federal, state, or local government that was not previously reported to the Board?**

☐ **YES***	☐ **NO**

If yes: please provide explanation below:

Explanation:

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:

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.

Signature of Owner: _____ **Date:** _____

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 _____.

KENTUCKY BOARD OF PHARMACY
State Office Building Annex,Suite 300
125 Holmes Street
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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 Information:

Facility Name:			
Address:			
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
- ☐ LLC
- ☐ Corporation
- ☐ Other

★★ Please provide the following information for each owner/partner/director/member/officer:

1.

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

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

2.

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

3.

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

5.

Name:	Title:
Email:	
Phone number(Business):	
Phone number(Home):	
Social Security Number:	Date of Birth:
Federal Employee ID Number:	

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

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

(Use supplemental information page if necessary)

III. Schedule of Hours:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
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:

Name:
Title:
Phone Number:
Email:

VI. Qualifying Questions:

1. **Have any owner [s], partner [s], officer [s], or agent been convicted of any felony under federal, state, and/or local laws that has not been previously reported to the Board?**

☐ **YES***	☐ **NO**

If yes: please provide explanation below:

Explanation:

2. **Has any owner [s], partner [s], officer [s] or agent had a license or permit related to drugs disciplined by any federal, state, or local government that was not previously reported to the Board?**

☐ **YES***	☐ **NO**

If yes: please provide explanation below:

Explanation:

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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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 Owner: _____ **Date:** _____

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 _____.

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.

I. Facility Information:

Name of Facility:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:

Email:
Phone number:
Fax Number:
Website Address:

II. Check and complete one of the following:

☐ **New Third Party Logistics → $400.00**

Proposed date of opening:

☐ **Ownership Change → $150.00**

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

(Confirmation statement from previous owner must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change → NO CHARGE**

Previous Name:

III. Registration Numbers and Expiration Dates:

DEA:	Exp. Date:

FDA:	Exp. Date:

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

Name:
Title:
Phone Number:
Email:

V. 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?**

☐ YES*	☐ NO

If yes: please provide explanation below:

Explanation:

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

☐ YES*	☐ NO

If yes: please provide explanation below:

Explanation:

3. **Has applicant, or any owner [s], partner [s], officer [s], or agent 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*	☐ NO

If yes: please provide explanation below:

Explanation:

4. **Has applicant, officer, partner or director ever applied for a license with this Board?**

☐ YES*	☐ NO

*If yes: please provide license or permit number below

License/Permit No.:

VI. Schedule of Hours:

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

VII. Ownership:

How is the facility registered with the Secretary of State?

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

★★ Please provide the following information for each owner/partner/director/member/officer:

1.

Name:	Title:

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

2.

Name:	Title:
Email:	
Phone number(Business):	
Phone number(Home):	

Social Security Number:	Date of Birth:
Federal Employee ID Number:	
Address (Business):	
CITY: STATE: COUNTY: ZIP:	
Address (Home):	
CITY: STATE: COUNTY: ZIP:	

3.

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

CITY:	STATE:	COUNTY:	ZIP:

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

4.

Name:	Title:

Email:

Phone number(Business):

Phone number(Home):

Social Security Number:	Date of Birth:

Federal Employee ID Number:

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

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

5.

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

(Use supplemental information page if necessary)

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

:

IX.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:

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: _____ **Date:** _____

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_____.

By: _____

Signature: _____

My Commission Expires _____ State of _____.

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
- ☐ Confirmation Statement of former owner for Section 2

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

Application for 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 https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal. 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:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Email:			

Phone Number:	
Fax Number:	
DEA Number:	Exp. Date:

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

☐ **New Wholesaler → $150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

☐ **Change of Ownership → $150.00**

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

(Confirmation statement of previous owner must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Type of Wholesaler

☐ **Wholesale Distributor**	☐ **Virtual Wholesale Distributor**
☐ **Medical Gas Wholesale Distributor**	☐ **Other Wholesaler:** _____ .

IV. Name, title, phone and email of the facility contact person:

Name:
Title:
Phone number:
Email:

V. 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?**

☐ **YES***	☐ **NO**

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?**

☐ **YES***	☐ **NO**

If yes: please provide explanation below:

Explanation:

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***	☐ **NO**

If yes: please provide explanation below:

Explanation:

VI. Schedule of Hours:

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

CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

VII. Ownership:

How is the facility registered with the Secretary of State?

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

★★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.

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

CITY:	STATE:	COUNTY:	ZIP:

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

2.

Name:	Title:

Phone number(Business):

Phone number(Home):

Social Security Number:	Date of Birth:

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

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

3.

Name:	Title:

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

4.

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

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

5.

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

(Use supplemental information page if necessary)

VIII. Proof of surety bond or equivalent pursuant to 201 KAR 2:105, Section 2.

☐ **YES**	☐ **NO**

IX. Does this facility have a Digital Distributor Accreditation ?

☐ YES*	☐ NO

If yes: please provide the number below

:

X. List of other states, districts, or territories in which licensed/permitted:

:

XI. Has this facility undergone any third-party inspections?

☐ YES*	☐ NO

If yes: please include inspection report

REQUIRED DOCUMENTATION FOR NON-RESIDENT FACILITIES MUST BE ENCLOSED:

- ☐ 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
- ☐ Third-Party Inspection Report (if applicable)

Supplemental Information Page:

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.

Signature of Owner/Officer and Title: _____ **Date:** _____

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

By: _____

Signature: _____

My Commission Expires _____ State of

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

Application for 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 https://secure.kentucky.gov/formservices/Pharmacy/VirtualTerminal. 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:			
Physical Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Mailing Address of Facility:			
CITY:	STATE:	COUNTY:	ZIP:
Email:			

Phone Number:	
Fax Number:	
DEA Number:	Exp. Date:

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

☐ **New Wholesaler → $150.00**

Proposed date of Opening:

(Filed with board 30 days in advance of opening)

☐ **Change of Ownership → $150.00**

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

(Confirmation statement of previous owner must be attached)

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

Date of Proposed Relocation:
Previous Address:

☐ **Name Change** → **NO CHARGE**

Previous Name:

III. Type of Wholesaler

☐ **Wholesale Distributor**	☐ **Virtual Wholesale Distributor**
☐ **Medical Gas Wholesale Distributor**	☐ **Other Wholesaler:** _____ .

IV. Name, title, phone and email of the facility contact person:

Name:
Title:
Phone number:
Email:

V. 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?**

☐ **YES***	☐ **NO**

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?**

☐ **YES***	☐ **NO**

If yes: please provide explanation below:

Explanation:

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***	☐ **NO**

If yes: please provide explanation below:

Explanation:

VI. Schedule of Hours:

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

CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:	CLOSE:

VII. Ownership:

How is the facility registered with the Secretary of State?

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

★★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.

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

CITY:	STATE:	COUNTY:	ZIP:

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

2.

Name:	Title:

Phone number(Business):

Phone number(Home):

Social Security Number:	Date of Birth:

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

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

3.

Name:	Title:

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

4.

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

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

5.

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

(Use supplemental information page if necessary)

VIII. Proof of surety bond or equivalent pursuant to 201 KAR 2:105, Section 2.

☐ **YES**	☐ **NO**

IX. Does this facility have a Digital Distributor Accreditation ?

☐ YES*	☐ NO

If yes: please provide the number below

:

X. List of other states, districts, or territories in which licensed/permitted:

:

XI. Has this facility undergone any third-party inspections?

☐ YES*	☐ NO

If yes: please include inspection report

REQUIRED DOCUMENTATION FOR NON-RESIDENT FACILITIES MUST BE ENCLOSED:

- ☐ 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
- ☐ Third-Party Inspection Report (if applicable)

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By: _____

Signature: _____

My Commission Expires _____ State of