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