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:			

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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:

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

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

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

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