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

*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 _____.