

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

1. Name of Pharmacy _____

Physical Address of Pharmacy _____

(Street and Number)

City _____ County _____ Zip _____

Phone Number _____ Fax Number _____

Mailing Address of Pharmacy _____

(Street and Number)

City _____ State _____ Zip _____

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

New Facility \$100.00

Proposed date of Opening _____

(Filed with Board 30 days in advance of Opening)

Renewal \$100.00

(Late Renewal Fee after June 30 . . . \$175)

Change of Ownership \$75.00

Date of Proposed Acquisition _____

Name of Previous Owner(s) _____

(Confirmation statement of previous owner must be attached)

Change of Address/Location \$75.00

Date of Proposed Relocation _____

Previous Address _____

Name Change \$ 5.00

Previous Name _____

2. Ownership:

Sole Proprietor Partnership Unincorporated Business Incorporated Business Other

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

3. Pharmacist-In-Charge (P.I.C.) and Registered Pharmacist(s):

Name	KY License No.	P.O.A.	Key
P.I.C. _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(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.

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

5. Schedule of Hours:

Monday . . . _____ A.M. to _____ P.M. Friday . . . _____ A.M. to _____ P.M.
Tuesday . . . _____ A.M. to _____ P.M. Saturday . . _____ A.M. to _____ P.M.
Wednesday _____ A.M. to _____ P.M. Sunday . . . _____ A.M. to _____ P.M.
Thursday . . . _____ A.M. to _____ P.M. **Please indicate if closed for lunch.** _____

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

6. 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):

7. Does pharmacy currently utilize an automated data processing system? Yes ___ No ___

If yes, identify the source for: hardware _____ software _____

8. Type of Pharmacy (Indicate all that apply):

- | | | | | |
|--------------------|--------------|----------|--------------|---------|
| Retail Independent | Retail Chain | Hospital | Nursing Home | Nuclear |
| Internet | Mail Order | Infusion | Out-of-State | Oxygen |

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)

(Signature of Owner)

(Date)

(Date)