| | | |
|---|---|---|
| Kansas | **STATE BOARD OF PHARMACY**<br>800 SW Jackson, Suite 1414<br>Topeka, Kansas 66612-1244<br>www.pharmacy.ks.gov (785)296-4056 | **REGISTRATION APPLICATION:**<br>**Institutional Drug Room**<br>Form BA-12 |

*All applications must be typed, be complete, and include all fees and supporting documentation before they will be processed by staff.*

## FEES

Enclose a check or money order payable to the Kansas State Board of Pharmacy in the amount of $20.00. Fees are nonrefundable.

## OWNERSHIP

The Owner is considered the "applicant" for purposes of this form. If the Owner is a corporate or other legal entity, please complete and attach the appropriate Ownership Form (S-310 Partnership, S-320 LLC, or S-330 Corporate).

**Please indicate if this is a new application or a change:**

☐ New Application  Change (Check all that apply): ☐ Address  ☐ Ownership  ☐ Name

Previous registration number: _____ Effective date of change: _____

## OWNER INFORMATION

| | | | |
|---|---|---|---|
| Name | | Other States Registered (abbrev.) | |
| Address | | | |
| City | State | Zip | County |
| Phone | Fax | | Email |

Ownership Type:

☐ Individual  Provide SSN: _____  ☐ Government Entity  Provide FEIN: _____

☐ Partnership  ☐ LLC  ☐ Corporation

Complete and attach the appropriate Ownership Form (S-310 Partnership, S-320 LLC, or S-330 Corporate)

## INSTITUTIONAL DRUG ROOM INFORMATION

| | | | |
|---|---|---|---|
| Name (printed on license) | | | |
| Physical Address (non-residential) | | | |
| City | State | Zip | County |
| Phone | Fax | | Email |

## AUTHORIZED AGENT INFORMATION (For partnerships, LLCs, nonprofits, and companies)

| | | | |
|---|---|---|---|
| Name | | Title | |
| Address | | | |
| City | State | Zip | County |
| Phone | Fax | | Email |

**Designate where all formal correspondence, notices, and renewals should be sent:**

☐ Owner  ☐ Physical Location  ☐ Authorized Agent



Initials: _____ **OFFICE USE ONLY**

Permit #: _____ Fee: $_____ Date: _____ Check #: _____

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| | | |
|---|---|---|
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## PHARMACIST-IN-CHARGE or RESPONSIBLE PRACTITIONER

| | | |
|---|---|---|
| Name | License Number | Hours/Week on duty in facility |
| Phone | Fax | Email |

## LICENSED PHARMACISTS (List all pharmacists working in facility. Attach additional pages if needed.)

| | |
|---|---|
| Name | License Number |
| Name | License Number |
| Name | License Number |
| Name | License Number |
| Name | License Number |
| Name | License Number |
| Name | License Number |
| Name | License Number |
| Name | License Number |
| Name | License Number |
| Name | License Number |
| Name | License Number |
| Name | License Number |
| Name | License Number |

## PIC or PRACTITIONER CERTIFICATION

*I declare under penalty of perjury under the laws of the State of Kansas that I am the pharmacist-in-charge acting on behalf of the applicant, and I hereby accept responsibility for operating in compliance with all state and federal laws, which shall include compliance with the Kansas Pharmacy Act and Kansas Controlled Substances Act.*

SIGNATURE _____ DATE SIGNED _____

## OWNER CERTIFICATION

*I declare under penalty of perjury under the laws of the State of Kansas that I have read and understand this application and that the information provided is true, correct, and complete to the best of my knowledge.*

SIGNATURE _____ DATE SIGNED _____



Revised 02/17