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|---|---|---|
| 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>**Pharmacy**<br>Form BA-02 |

*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 $112.00. 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). If the pharmacy is owned by other LLCs, partnerships, holding companies, etc., please submit information down to a person level of ownership.

## RETAIL DEALER PERMIT

If the applicant plans to sell more than 12 over-the-counter drugs in a store/facility while the pharmacy is closed, the applicant must also submit Form BA-10: Registration Application for Retail Dealer.

**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)

## PHARMACY INFORMATION

|  |  |  |  |
|---|---|---|---|
| Name | | | |
| Physical Address (non-residential, no PO Box) | | | |
| City | State | Zip | County |
| Phone | Fax | | Email |
| Store/Facility Hours | Pharmacy Hours of Operation | | Hours/Week Pharmacist on Duty |

## PHARMACY TYPE (Check all that apply)

- ☐ Retail – Chain
- ☐ Retail – Independent
- ☐ Hospital/Institution
- ☐ Ambulatory Surgical Center
- ☐ Mail Order
- ☐ Other: ________________________

Initials: _________ **OFFICE USE ONLY**

Permit #:________________ Fee: $_________ Date:__________ Check #: _______________

Kansas

**STATE BOARD OF PHARMACY**
800 SW Jackson, Suite 1414
Topeka, Kansas 66612-1244
www.pharmacy.ks.gov (785)296-4056

**REGISTRATION APPLICATION:**
**Pharmacy**
Form BA-02

## 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

## PHARMACIST-IN-CHARGE

| | | |
|---|---|---|
| Name | | License Number |
| Phone | Fax | Email |

☐Yes ☐No **Has the PIC ever been a PIC in Kansas before?**
If yes, Pharmacy Name: ________________________ License Number: ________________________

## DRUG SCHEDULES (Check all that apply)

☐ Schedule II narcotic
☐ Schedule II non-narcotic
☐ Schedule III narcotic
☐ Schedule III non-narcotic
☐ Schedule IV
☐ Schedule V

If you selected any Drug Schedules above, please provide either:

☐ A copy of the current DEA Registration
Current DEA Registration Number ____________________ Expiration Date ____________________

☐ The submission date for the pending DEA Registration Application ____________________

If you did not select any Drug Schedules above, please submit a completed K-TRACS Notice of Exemption from Reporting Form.

## ADDITIONAL INFORMATION

☐Yes ☐No 1. Does the pharmacy perform any compounding?
If yes, select all that apply: ☐ Sterile ☐Non-sterile

☐Yes ☐No 2. Does the pharmacy plan to have pharmacists or pharmacy interns administer immunizations?

☐Yes ☐No 3. Does the pharmacy provide electronic supervision services? If yes, please attach Form S-500.

☐Yes ☐No 4. Does the pharmacy receive electronic supervision services? If yes, please attach Form S-500.

☐Yes ☐No 5. Does the pharmacy plan to participate in the Kansas Medication Disposal Program through the Kansas Department of Health and Environment? If yes, please provide application date ______________________________.

☐Yes ☐No 6. Does the pharmacy use any automated drug delivery systems?
If yes and the automation is off-site, please email pharmacy@ks.gov and request the N-100 form.

## DISCIPLINARY INFORMATION

Applicant includes the legal ownership entity as well as each individual, owner, partner, corporate officer, or director.

☐Yes ☐No **1.** Has the applicant or any pharmacist employed by the applicant been convicted of any violation of the federal Food, Drug and Cosmetic Act?

☐Yes ☐No **2.** Has the applicant been convicted under any federal, state, or local law relating to drug samples, wholesale or retail drug distribution, manufacturing, dispensing, or distribution of any drug or controlled substance?

☐Yes ☐No **3.** Has the applicant or the PIC been convicted of any felony or drug-related misdemeanor?

☐Yes ☐No **4.** Has any license or registration, currently or previously held by the applicant or the PIC been surrendered to, denied, disciplined, censured, suspended, limited, placed on probation, or revoked by any state of federal government?

**If yes to any of the above questions, please attach Form S-300: Disciplinary History.**

☐Yes ☐No **5.** Has the applicant complied with all registration requirements under any previous or current licenses or registrations?

**If no to the above question, please attach a detailed explanation along with any relevant documentation.**

## PIC 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

**LICENSED PHARMACISTS** (List all pharmacists working in the pharmacy. Attach additional pages if needed.)

| | |
|---|---|
| Name | License Number |
| Name | License Number |
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PIC SIGNATURE

DATE SIGNED

**TECHNICIANS** (List all technicians working in the pharmacy. Attach additional pages if needed.)

| | | |
|---|---|---|
| Name | Registration Number | ☐ Part-Time ☐ Full-Time |
| Name | Registration Number | ☐ Part-Time ☐ Full-Time |
| Name | Registration Number | ☐ Part-Time ☐ Full-Time |
| Name | Registration Number | ☐ Part-Time ☐ Full-Time |
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| Name | Registration Number | ☐ Part-Time ☐ Full-Time |
| Name | Registration Number | ☐ Part-Time ☐ Full-Time |

PIC SIGNATURE

DATE SIGNED