



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

**REGISTRATION APPLICATION:
 Non-Resident Pharmacy
 Form BA-22**

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.

RESIDENT STATE

Attach a copy of your current pharmacy registration and an official license verification from your home-state indicating that the pharmacy is actively licensed and in good standing with the Board of Pharmacy. Also attach the most recent inspection report conducted within the past two years by the state of residence.

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.

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/APPLICANT INFORMATION

Name		Other States Registered (abbrev.)	
Address			
City	State	Zip	County
Phone	Fax		Email
Ownership Type:			
<input type="checkbox"/> Individual Provide SSN: _____		<input type="checkbox"/> Government Entity Provide FEIN: _____	
<input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> 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
Resident State	Registration Number	Original Issue Date	Expiration Date
Website		Can patients purchase prescriptions online? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Toll Free Phone Number		Store/Facility Hours	
Pharmacy Hours of Operation		Hours/Week Pharmacist on Duty	

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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AUTHORIZED RESIDENT AGENT INFORMATION (Per KAR 68-7-12a, must be filed with Kansas Secretary of State)

Name		Title	
Address			
City	State	Zip	County
Phone	Fax		Email

PHARMACIST-IN-CHARGE

Name	License Number	Licensure State
Phone	Fax	Email

PHARMACY TYPE (Check all that apply)

- Retail – Chain
- Retail – Independent
- Mail Order
- Other: _____

DRUG SCHEDULES (Check all that apply)

- Schedule II narcotic
- Schedule II non-narcotic
- Schedule III narcotic
- Schedule III non-narcotic
- Schedule IV
- Schedule V
- Other: _____

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

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Does the pharmacy perform any compounding? If yes, select all that apply: <input type="checkbox"/> Sterile <input type="checkbox"/> Non-sterile
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Does the pharmacy use any automated drug delivery systems? If yes, please provide the date of installation: _____ Type and exact physical location of system: _____

DISCIPLINARY INFORMATION

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

<input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Has the applicant or the PIC been convicted of any felony or drug-related misdemeanor?
<input type="checkbox"/> Yes <input type="checkbox"/> 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 or federal government?
If yes to any of the above questions, please attach Form S-300: Disciplinary History.	
<input type="checkbox"/> Yes <input type="checkbox"/> 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.	

