

**STATE BOARD OF PHARMACY**

800 SW Jackson, Suite 1414
 Topeka, Kansas 66612-1244
 www.pharmacy.ks.gov (785)296-4056
 pharmacy@ks.gov Fax (785) 296-8420

**REGISTRATION APPLICATION:
 Distributor: Prescription Drug,
 Controlled Substance, or Device
 Form BA-05**

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 \$240.00. Fees are nonrefundable.

REQUIREMENTS FOR NON-RESIDENT FACILITY

Attach a copy of your **current registration or permit** issued by the state of residence, the **most recent inspection report** conducted within the past two years by the state of residence or the National Association of Boards of Pharmacy, and the **S-350 Non-Resident Information form**.

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 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 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)			

DISTRIBUTOR INFORMATION

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

AUTHORIZED AGENT INFORMATION-This should be an individual preferably located at the facility.

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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SERVICES PROVIDED (Check all that apply)

- Prescription drugs (non-controlled)
- Nonprescription drugs
- Schedule II narcotic
- Schedule II non-narcotic
- Schedule III narcotic
- Schedule III non-narcotic
- Schedule IV
- Schedule V (includes pseudoephedrine, ephedrine)
- Devices

If you selected any Drugs 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 _____

Yes No **Are you planning to distribute as a manufacturer?**
If yes, provide your Manufacturer FDA Registration Number: _____ Expiration date: _____

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 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 2. Has the applicant been convicted of or entered a plea of no contest to any felony?
- Yes No 3. Has any license or registration, currently or previously held by the applicant been denied, disciplined, censured, revoked, suspended, or surrendered for the dispensing, manufacture or distribution of any drug or controlled substance?
- Yes No 4. Has the applicant ever furnished false or fraudulent material on any application made in connection with the dispensing, manufacture or distribution of any drug?

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?
- Yes No 6. Has the applicant complied with all requirements to maintain and make available to the Board or to any federal, state, or local law enforcement officials those records required by the Food, Drug, and Cosmetic Act?
- Yes No 7. Has each employee or associate engaged in any distribution activity had education, training, or experience sufficient for that individual to perform assigned functions in such a manner as to provide assurance that the product, quality, safety, and security will at all times be maintained as required by any federal or state law?

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

AUTHORIZED AGENT CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I understand any permit issued will be issued jointly to the applicant and myself, and I hereby accept responsibility as the authorized agent for such permit, 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