Kansas	**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:** **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 $150.00. Fees are nonrefundable.

RESIDENT STATE

Attach a copy of your **current pharmacy registration,** the **most recent inspection report** conducted within the past 18 months 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 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 INFORMATION

Name			
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			Attach a list of all state registration numbers held by this facility.
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? ☐ Yes ☐ No		NABP e-Profile ID
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	Kansas License Number	All non-resident pharmacies must have a Kansas-licensed pharmacist in charge per K.A.R. 68-7-12a.
Phone	Fax	Email

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

PHARMACY TYPE (Check all that apply)

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

DRUG SCHEDULES

If the facility holds a DEA registration, please select Drug Schedules below.

- ☐ 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 a copy of the current DEA Registration.

Current DEA Registration Number _____ Expiration Date _____

If you do not plan to send controlled substances into Kansas, you may be eligible for an exemption from reporting from K-TRACS. Please submit a completed K-10 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

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.

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REGISTRATION APPLICATION:
Non-Resident Pharmacy
Form BA-22

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

Name	License Number	State
Name	License Number	State
Name	License Number	State
Name	License Number	State
Name	License Number	State
Name	License Number	State
Name	License Number	State
Name	License Number	State
Name	License Number	State
Name	License Number	State
Name	License Number	State
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Name	License Number	State
Name	License Number	State

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

Revised 06/19