

**STATE BOARD OF PHARMACY**

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**SUPPLEMENTAL APPLICATION:
Non-Resident Information
Form S-350**

INSTRUCTIONS

This form and any additional documents must be submitted with the following facility applications when the facility is physically located outside of Kansas: **BA-22 Non-Resident Pharmacy, BA-16 Durable Medical Equipment, BA-05 Distributor, and BA-06 Non-Prescription Drug Distributor.** You are only required to complete the portion that corresponds with your application type.

FACILITY INFORMATION

Facility Name

Physical Address (non-residential, no PO Box)

City

State

Zip

Kansas Registration Number (if issued)

BA-22 NON-RESIDENT PHARMACY OR BA-16 DURABLE MEDICAL EQUIPMENT

Please provide the following:

- Have you shipped drugs and/or devices into Kansas in the previous 12 months: **Yes** **No**
If yes, provide the specific drugs and/or devices sent in and the locations they were sent to in Kansas.
- For Durable Medical Equipment facilities, provide a product list.
- Approximate number of Kansas patients the facility plans to serve annually or has served during the preceding 12 months: _____
- Copy or example of a prescription label for a Kansas resident.
- Has this facility ever been denied a permit, withdrawn an application for a permit, surrendered a permit during the course of an investigation or disciplinary matter, or had a permit revoked by any state board of pharmacy; any local, state, or federal government agency; or any local, state, or federal court?
 No **Yes** (If yes, attach list and provide a copy of the board, agency, or court decision document.)

BA-05 DISTRIBUTOR OR BA-06 NON-PRESCRIPTION DRUG DISTRIBUTOR

Please provide the following:

- Have you shipped drugs and/or devices into Kansas in the previous 12 months: **Yes** **No**
If yes, provide the specific drugs and/or devices sent in and the locations they were sent to in Kansas.
If no, provide a product list for the facility.
- Approximate number of Kansas customers the facility plans to serve annually or has served during the preceding 12 months: _____
- Has this facility ever been denied a permit, withdrawn an application for a permit, surrendered a permit during the course of an investigation or disciplinary matter, or had a permit revoked by any state board of pharmacy; any local, state, or federal government agency; or any local, state, or federal court?
 No **Yes** (If yes, attach list and provide a copy of the board, agency, or court decision document.)

CHANGE OF OWNERSHIP

Please provide the following:

- Power of Attorney giving permission for the new owner to operate under the previous owner's Kansas registration number.

OWNER/APPLICANT 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 on this form and in all associated statements and supporting documents is true, correct, and complete to the best of my knowledge.

OWNER OR AUTHORIZED AGENT_____
DATE SIGNED