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:** **Automated Drug Delivery System in Long-term Care Facility** Form BA - 21

INSTRUCTIONS

All forms must be typed, be complete, and include all supporting documentation before they will be processed by staff.
This form is to be completed by a **managing pharmacy**, located and registered in Kansas, who will have an automated drug delivery system located in a long-term care facility located and registered in Kansas. Please submit this form prior to the initial stocking or use of an automated drug delivery system. See K.A.R. 68-9-2(a) for definition of an automated drug delivery system.

FEES

For a new installation, enclose a check or money order payable to the Kansas State Board of Pharmacy in the amount of $20.00. Fees are nonrefundable.

Please indicate if this is a new installation or removal of automated drug delivery system:

☐ New Installation Installation Date: _____
☐ Removal of Automated Delivery System Removal Date: _____

MANAGING PHARMACY (Must be located and registered in Kansas)

Name			Kansas Registration Number
Physical Address			
City	State	Zip	County
Phone	Fax		Email
PIC Name			PIC License Number

LTC FACILITY RECEIVING AUTOMATED DRUG DELIVERY SYSTEM (Must be located and registered in Kansas)

Name			KDADS Registration Number
Physical Address			
City	State	Zip	County
Phone	Fax		Email

DRUG SCHEDULES (Check all that apply for this automated drug delivery system)

- ☐ 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 one of the following for the automated drug delivery system:

☐ Current DEA Registration Number _____ Expiration Date _____

☐ The submission date for the pending DEA Registration Application _____

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

Initials: _____ **OFFICE USE ONLY**

Permit #:_____ Fee: $_____ Date:_____ Check #: _____

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