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:** **County Health / Family Planning** Form BA-11

All applications must be typed, be complete, and include all fees and supporting documentation before they will be processed by staff.

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).

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: _____

Please indicate the facility type:

☐ Health Department
☐ Private Non-Profit Family Planning Clinic
☐ Indigent Care Clinic
☐ Federally Qualified Health Clinic

OWNER INFORMATION

Name		Other States Registered (abbrev.)	
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)

DEPARTMENT/CLINIC INFORMATION

Name		Hours/Week Pharmacist on Duty	
Physical Address			
City	State	Zip	County
Phone	Fax		Email

DESIGNATED REPRESENTATIVE 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 ☐ Designated Representative

Initials: _____ **OFFICE USE ONLY**

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

Revised 03/22

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PHARMACIST-IN-CHARGE

Name	License Number	Hrs/Wk on Duty at Facility
Phone	Fax	Email

LICENSED PHARMACISTS (List all pharmacists working in facility. Attach additional pages if needed.)

Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number

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

Revised 03/22