

**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:
 Pharmacy
 Form BA-02**

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.

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.

RETAIL DEALER PERMIT

If the applicant plans to sell more than 12 over-the-counter drugs in a store/facility while the pharmacy is closed, the applicant must also submit Form BA-10: Registration Application for Retail Dealer.

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)			

PHARMACY INFORMATION

Name			
Physical Address (non-residential, no PO Box)			
City	State	Zip	County
Phone	Fax		Email
Store/Facility Hours	Pharmacy Hours of Operation		Hours/Week Pharmacist on Duty

PHARMACY TYPE (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Retail – Chain | <input type="checkbox"/> Ambulatory Surgical Center |
| <input type="checkbox"/> Retail – Independent | <input type="checkbox"/> Mail Order |
| <input type="checkbox"/> Hospital/Institution | <input type="checkbox"/> Other: _____ |

Initials: _____	OFFICE USE ONLY
Permit #: _____	Fee: \$ _____ Date: _____ Check #: _____

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DESIGNATED REPRESENTATIVE INFORMATION (For partnerships, LLCs, nonprofits, and companies)

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

PHARMACIST-IN-CHARGE

Name		License Number
Phone	Fax	Email

- Yes No **Has the PIC ever been a PIC in Kansas before?**

If yes, Pharmacy Name: _____ License Number: _____

DRUG SCHEDULES (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Schedule II narcotic | <input type="checkbox"/> Schedule III non-narcotic |
| <input type="checkbox"/> Schedule II non-narcotic | <input type="checkbox"/> Schedule IV |
| <input type="checkbox"/> Schedule III narcotic | <input type="checkbox"/> Schedule V |

If you selected any Drug 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 _____

If you did not select any Drug Schedules above, please submit a completed K-10 K-TRACS Notice of Exemption from Reporting Form.

ADDITIONAL INFORMATION

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. Does the pharmacy perform any compounding?
If yes, select all that apply: <input type="checkbox"/> Sterile <input type="checkbox"/> Non-sterile |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. If the pharmacy offers any aspect of internet/digital pharmacy practice, does the pharmacy hold a Digital Pharmacy Accreditation through NABP (.pharmacy Verified Websites program)? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Does the pharmacy plan to have pharmacists or pharmacy interns administer immunizations? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Does the pharmacy provide electronic supervision services? If yes, please attach Form S-500. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Does the pharmacy receive electronic supervision services? If yes, please attach Form S-500. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Does the pharmacy plan to participate in the Kansas Medication Disposal Program through the Kansas Department of Health and Environment? If yes, please provide application date _____. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Does the pharmacy use an automated drug delivery system at its registered address? (K.A.R. 68-9-2(a) defines automated drug delivery system). If yes, please complete and submit Form N-100 Automated Drug Delivery System Notice with application. |



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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 or 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.

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

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

Name	License Number
Name	License Number
Name	License Number
Name	License Number
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PIC SIGNATURE

DATE SIGNED



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TECHNICIANS (List all technicians working in the pharmacy. Attach additional pages if needed.)

Name	Registration Number	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time
Name	Registration Number	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time
Name	Registration Number	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time
Name	Registration Number	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time
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PIC SIGNATURE

DATE SIGNED