

**STATE BOARD OF PHARMACY**

800 SW Jackson, Suite 1414
 Topeka, Kansas 66612-1244
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 pharmacy@ks.gov Fax (785) 296-8420

REGISTRATION APPLICATION:

Retail Dealer
Form BA-10

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 \$10. Fees are nonrefundable.

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

RETAIL DEALER INFORMATION

Name of Store (printed on license)			
Physical Address			
City	State	Zip	County
Phone	Fax		Email
Contact Person	Contact Person Direct Phone		Hours of Operation

DESIGNATED REPRESENTATIVE INFORMATION

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

STORE PROPRIETOR/MANAGER 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

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