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).

If you are an indigent care clinic, federally qualified health clinic, or mental health center and you plan to accept medications in the unused medication program, please complete the N-450: Notification of Intent to Participate Form.

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 ☐ Indigent Care Clinic

☐ Private Non-Profit Family Planning 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

Initials: _____ **OFFICE USE ONLY**

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

Revised 06/2023

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Designate where all formal correspondence, notices, and renewals should be sent:

☐ Owner ☐ Physical Location ☐ Designated Representative

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

PIC CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I am the pharmacist-in-charge (PIC) of the facility listed on this form, and I hereby accept responsibility for ensuring that all facility operations, supervision, and personnel are in compliance with all relevant state and federal laws and regulations, which shall include the Kansas Pharmacy Act, the Kansas Controlled Substances Act, and the Kansas Prescription Monitoring Program Act; that I am responsible for all PIC duties outlined in such laws and regulations.

SIGNATURE _____ DATE SIGNED _____