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	**NOTIFICATION OF INTENT TO PARTICIPATE:** **Accepting Entity** Form N-450

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 clinic or qualifying center as described in K.A.R. 68-18-2 that intends to accept medications in the unused medications program.

ACCEPTING ENTITY

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

CONSULTING PHARMACIST

Name		License Number
Phone	Fax	Email

RESPONSIBLE PARTY INFORMATION

This should be an individual working in the facility who is carrying out duties of the unused medications program.

Name		Title
Phone	Fax	Email

CONSULTING PHARMACIST

I declare under penalty of perjury under the laws of the State of Kansas that I have read and understand all statutes and regulations related to the Utilization of Unused Medications Program and hereby accept responsibility for operating this utilization of unused medication site 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 _____

RESPONSIBLE PARTY

I declare under penalty of perjury under the laws of the State of Kansas that I am the responsible party acting on behalf of the clinic or qualifying center, and I hereby accept responsibility for operating the utilization of unused medication program at this site 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 04/23