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:** **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:

☐ 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)

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)

- ☐ Retail – Chain
- ☐ Retail – Independent
- ☐ Hospital/Institution
- ☐ Ambulatory Surgical Center
- ☐ Mail Order
- ☐ Other: ____________________

Initials: ________ **OFFICE USE ONLY**

Permit #:______________ Fee: $________ Date:_________ Check #: ______________

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)

☐ Schedule II narcotic
☐ Schedule II non-narcotic
☐ Schedule III narcotic
☐ Schedule III non-narcotic
☐ Schedule IV
☐ 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

☐Yes ☐No 1. Does the pharmacy perform any compounding?
If yes, select all that apply: ☐Sterile ☐Non-sterile

☐ Yes ☐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)?

☐Yes ☐No 3. Does the pharmacy plan to have pharmacists or pharmacy interns administer immunizations?

☐Yes ☐No 4. Does the pharmacy provide electronic supervision services? If yes, please attach Form S-500.

☐Yes ☐No 5. Does the pharmacy receive electronic supervision services? If yes, please attach Form S-500.

☐Yes ☐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 ______________________.

☐Yes ☐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.

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 of 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 (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

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

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
Name	License Number
Name	License Number
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PIC SIGNATURE

DATE SIGNED

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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: Pharmacy
Form BA-02

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

Name	Registration Number	☐ Part-Time ☐ Full-Time
Name	Registration Number	☐ Part-Time ☐ Full-Time
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Name	Registration Number	☐ Part-Time ☐ Full-Time
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PIC SIGNATURE

DATE SIGNED