

## 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 BUSINESS APPLICATION:
Change in
Designated Representative
Form BA-55

All forms must be typed, be complete, and include all supporting documentation before they will be processed by staff.

## WHEN TO USE THIS FORM

Use this form when there is a change in designated rep (aka authorized agent, facility contact person, manager-in-charge, etc.) for a manufacturer, distributor, nonprescription drug distributor, third party logistics provider, nonprescription third party logistics provider, outsourcing facility, research or teaching institution, analytical lab, ambulance, retail dealer, health department or clinic, institutional drug room, sample distributor, or durable medical equipment registration.

DO NOT USE this form to change the pharmacist in charge at a pharmacy, non-resident pharmacy, or outsourcing facility.

FACILITY INFORMATION				
Name		Kansas Registration Number		
Facility Email				
OUTGOING DESIGNATED REPRE	SENTATIVE			
Name		Title		
Email		Last Day		
INCOMING DESIGNATED REPRES	SENTATIVE -This sho	uld be an individua	l preferably loca	ted at the facility.
Name		Title		
Address				Date of Birth
City	State	Zip	County	
Phone	Fax		Email	
First Day (this must be after outgoing designated representative's last day)				
Any license number held by the incoming Designated Representative and the state that issued:				
Any needse number held by the moonling besignated representative and the state that issued.				
DESIGNATED REPRESENTATIVE I declare under penalty of perjury under the myself, and I hereby accept responsibility as Pharmacy Act and Kansas Controlled Subst entities with the authority to possess prescri	laws of the State of Kansas s the designated representa ances Act and ensuring tha	tive for such permit, which t prescription-only drugs	ch shall include comp	liance with the Kansas
SIGNATURE			DATE SIGN	IED