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:** **Institutional Drug Room** Form BA-12

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 $25.00. 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).

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)

INSTITUTIONAL DRUG ROOM INFORMATION

Name (printed on license)			
Physical Address (non-residential)			
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

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

☐ Owner ☐ Physical Location ☐ Designated Representative

Initials: _____ **OFFICE USE ONLY**

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

Revised 06/2023

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DRUG SCHEDULES (Check all that apply)

- ☐ Schedule II narcotic
- ☐ Schedule II non-narcotic
- ☐ Schedule III narcotic
- ☐ Schedule III non-narcotic
- ☐ Schedule IV
- ☐ Schedule V
- ☐ Other: _____

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 _____

PHARMACIST-IN-CHARGE or RESPONSIBLE PRACTITIONER

Name	License Number	Hours/Week on duty in 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
Name	License Number
Name	License Number

PIC or PRACTITIONER 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

Revised 06/2023