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: Sample Drug Distributor
Form BA-15

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

WHEN TO USE THIS FORM

Use this form if you do not have a wholesale distributor registration/permit and are distributing only Sample Drugs.

FEES

Enclose a check or money order payable to the Kansas State Board of Pharmacy in the amount of $30.00. 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 owned by other LLCs, partnerships, holding companies, etc., please submit information down to a person level of ownership.

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)

DISTRIBUTOR INFORMATION

Name		Hours of Operation	
Physical Address			
City	State	Zip	County
Phone	Fax		Email

Initials: __________ **OFFICE USE ONLY**

Permit #:________________ Fee: $_________ Date:__________ Check #: _______________

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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

DRUG SAMPLES BEING DISTRIBUTED:

____

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____

____

☐ Yes ☐ No **Does the applicant plan to provide samples of the permitted controlled substance drugs?**
If yes, attach a copy of the current DEA Registration.
Current DEA Registration Number ____________________ Expiration Date ____________________

DESIGNATED REPRESENTATIVE CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I understand any permit issued will be issued jointly to the applicant and myself, and I hereby accept responsibility as the designated representative for such permit, which shall include compliance with the Kansas Pharmacy Act and Kansas Controlled Substances Act.

______________________________ ______________________________
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