

PENNSYLVANIA STATE BOARD OF PHARMACY

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st-pharmacy@pa.gov

PHARMACY APPLICATION (# 854 106, Rev. 1/17)

- Type of Transaction Requested (Check One)**
 () Proposed Pharmacy.....\$125.00 Fee
 () Change in Location.....\$125.00 Fee

IF THIS PHARMACY DISPENSES PRESCRIPTIONS, PLEASE AFFIX A PRESCRIPTION LABEL HERE.

Make fee payable to the "Commonwealth of PA."
Fees are not refundable. Note: A processing fee of \$20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

Proof of label is acceptable if label is on order. Label must include name, address, telephone number and space for DEA number.

Check here if label will be provided at inspection.

Name of pharmacy: _____
(The name on the permit, label and sign, if used, must be identical)

If a change in location, please note pharmacy permit number: _____

(New) Address of pharmacy: _____
Street
 _____, PA
City Zip Code

Federal Employer Identification Number (FEIN): _____

Contact person's name: _____

Contact person's phone and fax nos.: _____
Phone No. Fax No.

Contact person's e-mail address: _____

Contact person's address: _____
Street

City State Zip Code

Expected date the pharmacy will be ready for inspection: _____
(Month/Day/Year)

Please complete the following sections with regard to ownership of this pharmacy.

Full name of the pharmacy's owner: _____

The owner is a (check one):

- Corporation - List the names of the director and principal officers, the offices they hold, their home addresses and the percentage of stock owned in the spaces below.
- Limited Liability Company (LLC) - List the officers/members, the offices they hold (if any), their home addresses and the percentage of interest owned in the spaces below.
- Hospital - List the name of the hospital administrator and their home address along with the names of the hospital's principal officers, the offices they hold, their home addresses, and the percentage of interest owned in the spaces below.
- Nursing Home - List the name of the nursing home administrator and their home address along with the names of the nursing home's principal officers, the offices they hold, their home addresses, and the percentage of interest owned in the spaces below.
- Individual(s) - List the name(s) of the individual owner(s), their pharmacist license number(s) (if any), their home addresses, and the percentage of ownership in the spaces below.
- Limited Partnership - List the names of the principal officers (if any) and the names of the individuals overseeing the operation of the limited partnership, the offices they hold (if any), their home addresses and the percentage of interest owned in the spaces below.
- Other (specify) _____ - List the names of the director and the principal officers, the offices they hold, their home addresses and the percentage of interest owned in the spaces below.

If additional space is required, please provide the requested information on an 8 ½" X 11" sheet of paper and attach it to this application.

If applicable, please provide the following information:

Names of stockholders/interest holders with more than 10%	Home address	Percentage of stock/interest
_____	_____	_____
_____	_____	_____
_____	_____	_____

List the type of patient that this pharmacy serves (ex. inpatients, retail customers, etc.) _____

Does a medical practitioner have any proprietary interest in the pharmacy? Yes No
If "Yes", indicate the percentage of interest: _____%
If "Yes", please provide information regarding the involvement of the medical practitioner in the direction, control and daily operation of the pharmacy.

Are there any pending indictments of any nature or any alleged violations of the law governing the practice of pharmacy against any of the individuals listed on this application or have any of them been convicted of any crimes within the past ten years? Yes No
If yes, please give details on an attached sheet of paper.

Is this pharmacy located in a health care facility as defined in the "Health Care Facilities Act", is it or will it be periodically inspected by the Department of Health in accordance with the standards in the Pharmacy Act and Board Regulations, AND will the Department of Health forward copies of their inspection reports to the Board of Pharmacy office? () Yes () No

If you answered "Yes", please provide the following:

Name of health care facility: _____

Address of health care facility: _____

Type of health care facility (i.e. nursing home, hospital, etc.): _____

VERIFICATION

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911. I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

The prescription area of this pharmacy has all of the equipment and facilities that are required in the Pharmacy Act and Rules and Regulations and in the event of loss or breakage of any item on the equipment list, it will be replaced immediately.

I agree to display the pharmacy permit conspicuously and I understand that the pharmacy permit may not be transferred.

I agree to notify the Board immediately in the event that I should change location, change ownership, change title, change pharmacist manager, remodel or discontinue this pharmacy. I agree to notify the Board in event of a fire or flood or if the pharmacy permit has been lost or misplaced.

I agree, as a non-pharmacist owner, not to exercise control over the professional activities of the licensed pharmacists under my employ. I will not be involved in any pharmacy-related activity which requires the professional judgment of a licensed pharmacist.

Signature of the Registered Pharmacist Manager Date

Printed Name of Registered Pharmacist Manager

License Number: __RP-_____

AND

Signature of the Owner's Authorized Representative Date

Title: _____

Printed Name: _____

PENNSYLVANIA STATE BOARD OF PHARMACY

WHOLESALE VERIFICATION FOR A PROPOSED PHARMACY

*This page to be completed for a proposed pharmacy only.

We, _____, located at
_____ Pennsylvania Registered Wholesaler

Street Address City State

verify that we have on record a proposed order made by

Name of applicant(s)

Street Address City State

which indicates that he/they have an order of not less than \$5,000.00 worth of nonproprietary drugs and devices, at cost, under the name of:

Name of Pharmacy located at

Street Address City State

Signature of Wholesaler Date

This page must be submitted with the **original** signature of the wholesaler. Submission of a photocopy or faxed copy is unacceptable and may result in a delay in the processing of your application.

CONSTRUCTION QUESTIONNAIRE

1. Will the prescription area be at least 250 square feet? Yes () No ()
2. Within the prescription area, will the prescription working counter be at least 10 linear feet in length and 2 linear feet in width for 1 or 2 pharmacists working simultaneously? Yes () No ()
If more than 2 pharmacists will be working simultaneously, please note the number of pharmacists who will work simultaneously and the length and width of the prescription working counter:
Number of pharmacists working simultaneously _____
Length of counter _____ Width of counter _____
3. Will there be a telephone in the prescription area? Yes () No ()
4. Will there be a sink within the prescription area for use solely for pharmaceutical purposes? Yes () No ()
Will the sink be connected to hot and cold water? Yes () No ()
5. Are restroom facilities located reasonably close to, but outside of the prescription area? Yes () No ()
6. Will the pharmacy stock Schedule I controlled substances? Yes () No ()
If yes, will the Schedule I drugs be stored according to federal and state laws and regulations? Yes () No ()
- Please review Question 7 and check "N/A" (not applicable) if Question 7 does not apply: N/A ()
7. For pharmacies located within a retail establishment whose business hours differ:
a. Will the pharmacy be securely sealed off from the retail establishment? Yes () No ()
b. Will the barrier device which seals off the pharmacy reach from floor to ceiling? Yes () No ()
c. Will this barrier device be impenetrable by hand or the use of a reach extender? Yes () No ()
8. Please identify the number of pharmacists that are/will be employed at this pharmacy: _____

*Please refer to the Board's Regulations for additional information on construction and equipment requirements.

Please draw a skeleton sketch showing the floor plan of the prescription area as well as the other areas of the pharmacy. Failure to provide information on the **entire** pharmacy may result in a delay in the processing of your application. A minimum of 250 square feet is required for the prescription area.* Please provide detailed information on the placement of the counters, the sink and refrigerator, and the bathroom as well as the dimensions of the prescription area. A permit may be issued for a self-contained pharmacy having an entrance into an adjoining store that owns the pharmacy or is otherwise affiliated with it. Blue prints are not accepted in lieu of this sketch. If more space is required, please attach additional 8 ½" X 11" sheets of paper to this application.

*Board Regulation Section 27.1 defines "Prescription area" as "That area of the pharmacy used for compounding, legend drug storage and other activities necessary to the practice of pharmacy. The term does not include waiting counters or display space attached to the waiting counters."

MANDATORY EQUIPMENT – ARE THE FOLLOWING PRESENT?

A refrigerator that is:

1. Used solely for the storage of drugs requiring refrigeration,
2. Is equipped with a thermometer or a temperature monitoring device, and
3. Is located in the prescription area? () Yes () No

Additional equipment and supplies necessary to enable the pharmacy to properly prepare and dispense prescriptions consistent with its scope of practice? () Yes () No

Prescription files for keeping prescriptions of nonproprietary drugs and controlled substance prescriptions? () Yes () No

Current copies of the Pharmacy Act and Rules and Regulations? () Yes () No

Federal and Commonwealth statutes and regulations pertaining to the practice of pharmacy? () Yes () No

An adequate reference library which meets the standards as outlined in Board Regulation Section 27.14(c)(6) ? () Yes () No

A stock of nonproprietary drugs and devices which will inventory, at cost, at least \$5,000.00 (for change in location only)? () Yes () No

Please Note:

New pharmacy applicants are permitted to open when the permit number has been assigned. The permit does not have to be received and displayed prior to the pharmacy opening. The permit must be posted upon receipt. The pharmacy permit number will not change with the processing of this application for a change in location.

A pharmacy that fails the inspection will be required to pay \$115.00 for re-inspection. It will be the responsibility of the pharmacy owner to notify the Board office in writing when the pharmacy is ready for re-inspection.

Correcting any deficiency or violation noted on the inspection report for a change in location will be the responsibility of the owner. The Board will grant a period of not more than thirty days to correct the deficiency. Failure to do so will be just cause for the Board to take other appropriate action.

It is your responsibility to maintain a copy of this and all documents submitted to the Board or received from the Board for your future reference.

The information contained in this application is valid for only one year. If the application is pending and the pharmacy has not passed its required inspection within one year of the original date of submission of this application, the Board will request submission of a new application along with the required application fee.

Please respond to the following questions with regard to this pharmacy's proposed floor plans:

1. The Board has the same standards for security for all pharmacies. Is this pharmacy located in a building with other occupants? () Yes () No

If your response is "Yes", please also respond to the following questions:

- a. Will the pharmacy be securely sealed off from the other occupants? () Yes () No
b. Will the barrier device which seals off the pharmacy reach from floor to ceiling? () Yes () No
c. Will this barrier device be impenetrable by hand or the use of a reach extender? () Yes () No

2. Is a pneumatic tube present? () Yes () No

If a **pneumatic tube** is being used by the pharmacy, verify the following:

- a. It is a one-stop system (drugs go directly from the prescription area to the patient at the delivery point without possibility of the drugs being diverted elsewhere). () Yes () No
b. There are proper audio-visual facilities where the pharmacy's employees can see who is picking up the medication and speak directly with them. () Yes () No
c. The pneumatic tube system is located within the prescription area and not in a service area. () Yes () No

*If you answer "No" to parts a., b., and/or c., please provide more detailed information on how security and confidentiality are maintained when using this pneumatic tube system.

3. Is a drive thru present? () Yes () No

If a **drive thru** is present, verify the following:

The drive thru is similar in construction to the metal sliding drawers used at banks, including the ability to communicate with the customers. () Yes () No

*If you answer "No" to the second part of this question, please provide additional information on the operation of this drive thru and describe how security and confidentiality are maintained.

4. Can a work counter be approached by the public? () Yes () No

If a **work counter** can be approached by the public (ex. opening at work counter or window at work counter), please respond to the following questions:

- a. How far from the floor will the bottom of the window or opening be? _____ inches
Note: The Board has set a standard that the barrier between a work counter (that can be approached by the public) and the customer must be at least 50 inches in height.
b. Is a window present? () Yes () No
If a window is present, will the glass be frosted? () Yes () No
c. Will a display be set in front of the window or opening? () Yes () No
If so, how tall and wide will the display be? _____ inches x _____ inches
d. How will unauthorized access to drugs and confidential patient information be prevented? _____

[] Check box if claiming a Business fee exemption for veteran-owned and reservist-owned small business under Act 135 of 2016 (51 Pa.C.S. §§ 9610-9611)

Under Act 135 of 2016, veterans and reservists starting or opening a small business in the Commonwealth are exempt from the payment of a business fee effective January 2, 2017. Therefore, the board will waive the initial application fee for veteran- or reservist-owned small businesses as follows:

1. The veteran/reservist owner(s) must certify below that they are starting a small business in the Commonwealth. A **small business** must be independently owned, not dominant in its field of operation and employ 100 or fewer employees. The business must be owned AND controlled by a veteran or reservist. For businesses with multiple owners, at least 51% of the ownership interest must be held by veterans/reservists to claim the exemption.
2. The veteran/reservist owner(s) must attach proof of the veteran's or reservist's status at the time the initial application is submitted. Such proof includes a legible photocopy of:
 - A Federal DD-214 form
 - A Federal NGB-22 form
 - A valid Federal Veterans' Administration card or
 - A valid Department of Defense-issued military identification card

CERTIFICATION STATEMENT:

I hereby certify that I am applying for this license in order to start or open a small business in the Commonwealth of Pennsylvania as defined above, that I am a veteran or reservist as evidenced by the attached documentation, and that at least 51% of the ownership of the small business is veteran- or reservist-owned.

Signature of veteran/reservist applicant

Date

Printed name of veteran/reservist applicant

** Use additional sheets as necessary for each veteran/reservist owner