

## **CANCER DRUG REPOSITORY APPLICATION INSTRUCTIONS #854 116**

Please review all program requirements under the Commonwealth of Pennsylvania, State Board of Pharmacy's Cancer Drug Repository Program 49 Pa. Code § 27.501 - 27.506 before completing the "Cancer Drug Repository Application." A response or explanation must be provided for all sections. Approval may be delayed if appropriate responses in all sections are not provided.

### **I. APPLICANT INFORMATION**

Please provide all requested information about the pharmacy where the service will be provided.

### **II. PHARMACY SERVICES**

- a. Indicate all applicable descriptions of the pharmacy services provided by this pharmacy.
- b. If any of these services are offered at a location other than the pharmacy's registered address, please provide the location and the manner in which these services are provided.

### **III. OWNERSHIP DESCRIPTION**

- a. List the name of the entity that directly owns the pharmacy permit.
- b. Indicate the type of ownership.
- c. Provide the Federal Employer Identification Number.
- d. Provide the names of the pharmacy owner's director, principal officers, members and administrator, the offices they hold, their home addresses and the percentage of interest/stock owned. If an individual directly owns the pharmacy permit, please provide his pharmacist license number (if any), his home address and the percentage of ownership.
- e. If an entity/individual holds more than 10% of interest/stock in the pharmacy's owner, please provide the name of the entity/individual, home address and percentage of interest/stock owned.

### **IV. CERTIFICATION**

A licensed pharmacist who is employed by or under contract with the pharmacy and who has been delegated the responsibility to receive delivery of donated cancer drugs must certify that the pharmacy meets the eligibility requirements for participation in this program by fully completing this section.

### **V. VERIFICATION**

If the pharmacist who signs the certification statement had assistance in completing any part of the application, the individual who assisted in completing the application must fully complete this section. If the pharmacist who completed the certification prepared the entire application himself, this section may be left blank.

Commonwealth of Pennsylvania  
State Board of Pharmacy  
PO Box 2649, Harrisburg, PA 17105-2649  
Phone - (717) 783-7156 Fax - (717) 787-7769  
st-pharmacy@pa.gov

**CANCER DRUG REPOSITORY APPLICATION #854 116**

**I. APPLICANT INFORMATION:**

\_\_\_\_\_  
**PHARMACY'S REGISTERED NAME**

\_\_\_\_\_  
**PHARMACY PERMIT NUMBER**

\_\_\_\_\_  
**STREET ADDRESS**

\_\_\_\_\_, PA  
**CITY** **ZIP CODE**

\_\_\_\_\_  
**BUSINESS TELEPHONE NUMBER**

**II. TYPES OF PHARMACY SERVICES PROVIDED AT THIS PHARMACY:**

_____ Community	_____ Clinic	_____ Research
_____ Hospital	_____ Managed Care	_____ Internet
_____ Chain	_____ Nuclear	_____ Nursing Home
_____ Long Term Care	_____ Independent	_____ HMO
_____ Veterinary	_____ Home Health	_____ Consultant
_____ Mail Order	_____ Correctional Facility	_____ Other (specify below)
_____ Intravenous	_____ Pharmacy Service	
_____ Therapy	_____ Center	

If the pharmacy provides services somewhere other than at the pharmacy's registered address, please identify the location and manner in which these services are provided 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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**III. PHARMACY OWNERSHIP:**

\_\_\_\_\_  
NAME OF THE ENTITY THAT DIRECTLY OWNS THE PHARMACY PERMIT

\_\_\_\_\_  
IDENTIFY THE TYPE OF OWNERSHIP (ex. corporation, LLC, LP, hospital, nursing home, etc.)

\_\_\_\_\_  
FEDERAL EMPLOYER IDENTIFICATION NO.

Please list in the spaces below the names of the pharmacy owner's director, principal officers, members, and administrator, the offices they hold, their home addresses and the percentage of interest/stock owned. If individuals directly own the pharmacy permit, list their name(s), their pharmacist license number(s) (if any), their home addresses, and the percentage of ownership in the spaces below. You may include attachments if additional space is required.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If an entity/individual holds more than 10% of interest/stock in the pharmacy's owner, please provide the entity's/individual's name, home address and percentage of interest owned in the spaces below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IV. CERTIFICATION:**

**This certification is to be completed by a licensed pharmacist employed by or under contract with this pharmacy:**

I verify that the above-listed pharmacy meets the eligibility requirements for participation in the Cancer Drug Repository Program as outlined in Board Regulation Section 27.503(c). This pharmacy holds an unrestricted permit in good standing and agrees to participate in the program in accordance with the Pharmacy Act, Board Regulations and the Cancer Drug Repository Program Act. I have been delegated the responsibility to receive delivery of donated cancer drugs at the designated delivery area in the pharmacy.

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. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate. I verify that this form 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 pursuant to 18 PA C.S. Section 4911.

\_\_\_\_\_  
**Pharmacist's signature**

\_\_\_\_\_  
**Date**

**Pharmacist's printed name:** \_\_\_\_\_

**Pharmacist's license number:** \_\_\_\_\_

**Pharmacist's telephone number:** \_\_\_\_\_

**V. VERIFICATION:**

**If someone other than the pharmacist whose name is listed above assisted in the completion of any part of this application, the person who assisted in the completion of the application must sign the verification statement below.**

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. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license or certificate. I verify that this form 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 pursuant to 18 PA C.S. Section 4911.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Signer's printed name:** \_\_\_\_\_

**Signer's telephone number:** \_\_\_\_\_