PENNSYLVANIA STATE BOARD OF PHARMACY
PO BOX 2649
HARRISBURG, PA 17105-2649
(717) 783-7156
www.dos.state.pa.us/pharm

PHARMACY APPLICATION (# 854 106, Rev. 7/09)

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:_____

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

This pharmacy is owned by a (please check **one**) and **list the name** of the owner:

( ) Corporation – Corporation Name:_____
( ) Limited Liability Company (LLC) - LLC Name:_____
( ) Hospital – Hospital Name:_____
( ) Nursing Home – Nursing Home Name:_____
( ) Individual(s) – Name(s):_____

Please list the names of the principal officers, the offices they hold, their home addresses and the percentage of stock owned **OR** list the name of the hospital or nursing home administrator and their home address along with the names of the hospital or nursing home's principal officers, the offices they hold, their home addresses, and percentage of stock owned **OR** list the name(s) of the individual owner(s), their pharmacist license number(s) (if any), their home addresses, and the percentage of ownership. 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** with more than 10%	Home Address	Percentage of stock

Does a medical practitioner have any proprietary interest in the pharmacy? ( ) Yes ( ) No
If yes, indicate the percentage of interest:_____%

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 crime within the past ten years? ( ) Yes ( ) No
If yes, please give details on an attached 8 ½ X 11 sheet of paper.

List the type of patient that this pharmacy will serve (ex. retail customers, hospital inpatients, etc.):_____

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

The statements in this application are true and correct to the best of my knowledge, information, and belief. I understand that false statements are subject to the penalties of 18 PA C.S. § 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. § 4911.

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 the 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 judgement of a licensed pharmacist.

_____ _____
Signature of the Registered Pharmacist Manager and Date

AND _____ _____
Signature of the (check one below) and Date
( ) Registered Agent of Corporation
( ) Registered Agent of LLC
( ) Hospital/Nursing Home Administrator
( ) Individual Owner

PENNSYLVANIA STATE BOARD OF PHARMACY

PHARMACY APPLICATION

*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:

_____located at
Name of Pharmacy

_____
Street Address City State

_____ _____
Signature of Wholesaler Date

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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.

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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 ( )

*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

Beginning with the pharmacist manager, list all of the registered pharmacists employed at this pharmacy. 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.

Name	License Number	Exp. Date

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

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

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? _____

      _____

      _____

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.

If this application is in order but the pharmacy has not passed its required inspection within one year of the original date of submission of this application, the Board may request submission of a new application or part of an application along with the required application fee.