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

PHARMACY APPLICATION (# 854 107, Rev. 9/09)

Type of Transaction Requested (Check One)

( ) Change in Title……..……$45.00 Fee
( ) Change in Ownership…….. $30.00 Fee
( ) Change in Controlling Interest…….$30.00 Fee

IF THIS PHARMACY DISPENSES PRESCRIPTIONS, PLEASE AFFIX A SAMPLE 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 D.E.A. number.

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

Pharmacy permit number:_____

Address of pharmacy:_____
Street

_____,PA_____
City Zip Code

New title of pharmacy:_____
(Change in title only)

Date new title goes into effect:_____
(Change in title only)

Contact person's name and phone number:_____

Contact person's e-mail address:_____

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

Name	License Number	Exp. Date

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

This pharmacy is/will be 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

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:_____%

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 sheet of paper.

*****The permit number will NOT change with the processing of this application*****

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 Board 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

NOTICE

The Pennsylvania Board of Pharmacy has the following policy regarding change in ownership/controlling interest/title of an established pharmacy. The new owner will be responsible for the operation and practice of pharmacy in accordance with the Pharmacy Act and Board Regulations. Once the application is processed, the Board will notify the following agencies of the change: DEA, PACE, Department of Public Welfare, Department of Health, and NCPDP.

The Board may request submission of a new application or part of an application along with the required application fee if any discrepancies with this application have not been appropriately addressed within one year of the date that the application was originally received in the Board office. The pharmacy permit may also be subject to disciplinary action for a violation of Board Regulation Section 27.11(d) if a properly completed application is not submitted to the Board office within 30 days of the change ownership, controlling interest and/or title.

CHANGE OF OWNERSHIP VERIFICATION
(For change in ownership ONLY)

I/We,_____, current/former owner(s)

of an established pharmacy operating under the title of_____,

located at_____

with permit # _____, do hereby certify that a purchase agreement

was/will be signed on _____with_____
(New Owner(s))

and that the actual ownership transfer date is _____.

Signature_____
(Former Owner(s))

Signature_____
(New Owner(s))

If applicable, please provide the pharmacy's new Federal Employer Identification No. (FEIN):_____

CHANGE OF CONTROLLING INTEREST VERIFICATION
(For change in controlling interest ONLY)

I/We,_____, owner(s) of an

established pharmacy operating under the title of_____

located at_____

with permit #_____, do hereby certify that controlling interest changed

as of _____and as indicated on page 2 of this application.

Signature_____
(Owner or Registered Agent)

If applicable, please provide the pharmacy's new Federal Employer Identification No. (FEIN):_____