

MINNESOTA BOARD OF PHARMACY

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APPLICATION FOR A PHARMACY LICENSE

LICENSE EXPIRES JUNE 30 OF EACH YEAR

FEE FOR NEW PHARMACY AND OWNERSHIP CHANGE: \$190.00 + \$19.00* = \$209.00

*As of October 1, 2010, license and registration fees include a 10% electronic licensing surcharge, with a \$5.00 minimum. These funds are sent to the Minnesota Office of Enterprise Technology to implement one portion of a state electronic licensing system. The surcharge will be in place through June 15, 2015.

NO FEE FOR NAME CHANGE OR ADDRESS CHANGE

Make Check Payable to: Minnesota Board of Pharmacy

NO RETURN OR REFUND OF FEES

State of Minnesota Taxpayer Identification Number: Federal 41-6007162 - State 4405717

NEW PHARMACY:

Date of proposed opening in Minnesota

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CHANGE IN:

Date of proposed change

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- Ownership Formerly: _____
- Name Formerly: _____
- Address Formerly: _____
- Location/dimension/physical layout - Please attach copies of the plans or a sketch of the new location or a remodel. Make sure the plans or sketches provide the dimensions of the pharmacy and of features such as countertops and the counseling area. Amount of space being licensed: _____ square feet

HOURS: M-F _____ to _____ Saturday _____ to _____ Sunday _____ to _____

PHONE NUMBER: _____ FAX NUMBER: _____

E-MAIL ADDRESS: _____

1. Print, type, or check all applicable boxes.

Pharmacy Name: _____
 Street Address: _____
 City, State, Zip: _____

2. Check the appropriate item and complete ownership information:

Sole Proprietor; Partnership; Limited Liability Partnership; Corporation; Limited Liability Corp

Fill in: Name of Sole Proprietor, Partnership, or Corporation: _____

Address: _____
 City, State, Zip: _____

Partnership or Limited Liability Partnership: List all active and inactive partners. If a new partnership or limited liability partnership, please attach a copy of the partnership papers.

Name	Address	RPh?	% of Ownership

Corporation or Limited Liability Corporation: List all shareholders owning 20% or more of the voting stock, all officers and their titles. If a new Corporation or Limited Liability Corporation, please attach corporation papers.

Name	Address	RPh?	% of Ownership

List the state of incorporation: _____

List the number of shares of common or voting stock issued: _____

All pharmacies, in-state and out-state should answer the following questions:

3. Please check all categories of licensure that apply to your pharmacy.

- A. Community/Outpatient
 B. Hospital
 C. Home Health Care
 D. Long Term Care
 E. Nuclear
 F. Central Service
 G. Limited Service*
 H. Nonsterile Product Compounding
 I. Sterile Product Compounding
 J. Veterinary
 K. Non-Resident
 L. Federal

* Please submit a description of the services that you propose to provide.

4. Does the owner of this pharmacy own 4 or more pharmacies under this ownership: Yes No

5. Employees: (Please attach another sheet if necessary)

Pharmacist Name – Full-time and Part-time	License #	Hrs Per Week

Technician Name – Full-time and Part-time	Regis. #	Hrs Per Week

6. Please answer the following:

- (a) On behalf of the owner, if the applicant is a sole proprietorship
 (b) On behalf of each partner, if the applicant is a partnership or a limited liability partnership
 (c) On behalf of the corporation, if the applicant is a corporation or a limited liability corporation, and on behalf of each officer, director, or shareholder owning 20% or more of the voting stock of the corporation.

- a. Has the applicant been convicted in any court of a felony? Yes No
- b. Has the applicant habitually indulged in the illegal use of narcotics, stimulants, or depressant drugs; or habitually indulged in intoxicating liquors in a manner which could cause incompetence in the practice of pharmacy? Yes No
- c. Has the applicant ever made application for a license to operate a pharmacy in this state or any other state? Yes No
- (1) If yes, was the application denied by the Board of Pharmacy? Yes No
- (2) If denied, for what reason? _____
- (3) If the license was granted, was it later suspended, revoked, or placed on probation?

Yes No

(4) Did the Board, in connection with any violations, issue any warnings or reprimands?

Yes No

(5) If yes, what was the nature of the violation? _____

d. Has the applicant been convicted of theft of drugs or the unauthorized use, possession, or sale thereof?

Yes No

MINNESOTA IN-STATE PHARMACIES PLEASE COMPLETE #7 – 12.

7. PLEASE COMPLETE THE FOLLOWING:

1981 Laws, Chapter 346 requires that you supply us with information concerning your worker's compensation insurance, for this firm, prior to the issuance of the license. Please check the applicable box below:

Self-insured, please attach a copy of the Certificate of Exemption from the Insurance Commissioner.

I DO NOT employ anyone.

I HAVE paid or otherwise compensated employees, therefore, I am furnishing the following information:

Insurance Company Name: _____

Street Address: _____

City, State, Zip Code: _____

Insurance Policy Number: _____ Date it Expires: _____

8. Does the pharmacy have all the required equipment listed in 6800.1050? Yes No

9. If this application is for a new pharmacy, submit a scaled drawing or blueprint, indicating the following, with this application:

- | | |
|--|-----------------------------|
| A. Access | B. Floor space dimensions |
| C. Physical security around the proposed pharmacy area | D. Location of the insulin. |
| E. Location of prescription compounding area | F. Refrigerator |
| G. Location of the hypodermic syringes and needles | H. Non-Prescription area |
| I. Location of the insulin. | J. Sink |
| K. Patient counseling area (with dimensions) | |
| L. Location of the signs that say "Pharmacy" and/or "Drug" | |

10. Does the applicant plan to extend drug storage/distribution to off-site locations, i.e., emergency kits, automated drug distribution systems, etc.? Yes No

11. If this application is for a hospital pharmacy, please submit the following with the application:

- A. A copy of the procedure used to obtain emergency drugs, when the pharmacy is closed.
- B. Samples of drug orders, prescriptions, requisitions, or other records used to order medications and filed in the pharmacy to account for drugs dispensed.

12. If this application is for a hospital pharmacy, please check the scope of services provided:

Hospital in-patients Emergency out-patients Long-term care residents

Other, please explain: _____

MINNESOTA OUT-OF-STATE PHARMACIES, PLEASE COMPLETE #13 a-f:

13. a. Does the applicant comply with all lawful directions and requests for information from the Board of Pharmacy in all states in which it is licensed or registered? Yes No
- b. Does the applicant agree to respond directly to all communications from the Minnesota Board of Pharmacy concerning emergency circumstances arising from the dispensing of drugs to residents of this state? Yes No
- c. Does the applicant maintain its records of drugs dispensed to residents of Minnesota so that the records are readily retrievable from the records of other drugs dispensed? Yes No
- d. Does the applicant agree to cooperate with the Minnesota Board of Pharmacy by providing information to the Board of Pharmacy of applicant's home state concerning matters related to the dispensing of drugs to residents in Minnesota? Yes No
- e. Minnesota rules require a toll free telephone number to facilitate communication between patients in Minnesota and a pharmacist, who has access to the patients' records, at the pharmacy? Please provide the number. _____
- f. Please attach a copy of your current license from the state in which your facility is located and the most recent inspection report from that state or a letter explaining that your state does not require either licensure or inspections.

ALL APPLICANTS MUST COMPLETE #14-16.

14. Minnesota Statute 152.126 requires all pharmacies licensed in the state of Minnesota to report daily, the dispensing of schedule II, III and IV controlled substances to the Board or its designated vendor. Pharmacies that will never dispense the above noted controlled substances and licensed hospital pharmacies that distribute controlled substances for inpatient hospital care are exempt from reporting.

Is this application for a pharmacy that :

- a) Will never dispense schedule II, III and IV controlled substances in the State of MN?

Yes No

- b) Is a hospital pharmacy that distributes controlled substances for inpatient hospital care only?

Yes No

If you answered, "No" to both questions above, please review the detailed information on reporting to the MN Prescription Monitoring Program (PMP) in the "Dispenser's Implementation Guide" on the PMP website at www.pmp.pharmacy.state.mn.us under "Other Forms and Documents".

15. Please type or print:

I, _____, the undersigned, hereby certify that I am a licensed pharmacist in the state of _____, holding License Number _____, and that I have been designated as Pharmacist-in-charge of the pharmacy named in this application and I do hereby assume professional responsibility for said pharmacy as the Pharmacist-in-charge.

Signature of the Pharmacist-in-charge Date

I will be the permanent Pharmacist-in-charge. Yes No

16. The data you supply on this form will be used to assess your qualifications for licensure. You are not legally required to provide this data, but we will not be able to grant the license without it. This data will constitute a public record, if and when the licensure is granted, and, at that time, copies may be issued to anyone.

I have read the above statement and I agree to supply the data on this form with full knowledge of the information provided in that statement. In addition, I, the undersigned, do hereby certify that all of the information contained in this application is true and correct and that the firm will be operated in compliance with all applicable laws and regulations.

Name and title of applicant

Signature of Applicant, Owner, Partner
or Administrative Officer

Date

Please type or print

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