

License # \_\_\_\_\_

Date Issued: \_\_\_\_\_



# Application for a Permit to Operate as a Charitable Clinic

PART I: GENERAL INFORMATION						
1.	Clinic Name					
2.	Physical Address					
	Street					
	City					
	State		Zip			
3.	Mailing Address					
	Street or PO Box					
	City					
	State		Zip			
	Telephone Number		Fax Number			
	Website					
4.	Type of Charitable Clinic	<input type="checkbox"/> Clinic of the Arkansas Department of Health <input type="checkbox"/> Other Charitable Clinic				
5.	Person with whom the Arkansas State Board of Pharmacy may communicate regarding this application:					
	Name					
	Telephone		Cell Phone			
	Email					
6.	Is this a change of Pharmacist in Charge? If yes, who was the previous Pharmacist in Charge?					Yes [ ] No [ ]
7.	Hours of Operation					
	Circle all that apply		Please express in terms of a.m. and p.m.			Total Hours per Day
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	Sunday	a.m. p.m.
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	Monday	a.m. p.m.
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	Tuesday	a.m. p.m.
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	Wednesday	a.m. p.m.
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	Thursday	a.m. p.m.
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	Friday	a.m. p.m.
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	Saturday	a.m. p.m.
8.	Total Hours per MONTH					
9.	Will the clinic dispense controlled substances					Yes [ ] No [ ]
	If yes, what is the Federal DEA Permit Number					
	What is the Name of DEA Registrant					
10.	Individual or Group Responsible for the Clinic:					
11.	Type of Medications to be dispensed:					
12.	Pharmacist in Charge:					
13.	Do you plan to charge clinic patients any type of fee, or ask for donations? If yes, please explain on a separate sheet.					Yes [ ] No [ ]

<b>PART II: PERSONNEL</b>					
<b>14.</b>	<i>List all individuals filling prescriptions or performing any function considered to be the practice of pharmacy for this business. You may attach additional sheets if needed. <b>YOU MUST NAME A PHARMACIST IN CHARGE.</b></i>				
Name	License #	Hours/Wk	Age	Degree	Hire Date
<b>Pharmacist in charge</b>					
<b>Other pharmacists</b>					
<b>Interns</b>	License #	Hours/Wk			
<b>Pharmacy Technicians</b>	Registration #				

**PART III: DOCUMENTATION**

- Attach a copy of the charitable clinic pharmacy’s *Policies and Procedures* . These *Policies and Procedures* must be approved by the Board.
- Attach a copy of the floorplan.
- Attach a copy of the formulary
- Attach a copy of the non-profit or organizational certificate, if applicable.

**PART VIII: CERTIFICATION** *Please read carefully and sign below.*

I swear, or affirm that all statements made herein and on the attached forms are true and correct. All of the provisions of Arkansas laws and regulations related to the practice of pharmacy in Arkansas will be faithfully observed during the period any permit issued may be in force and effect.

I swear and affirm that I know where to locate the statutes and regulations related to the practice of pharmacy in Arkansas. (They are available online at the Arkansas State Board of Pharmacy website in the Pharmacy Lawbook section under the Pharmacy Practice Act § 17-92-101 *et seq* and Regulations 1 through 12.)

By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form, that I have personally completed this form, that the information given in this application is true, correct and complete to the best of my knowledge. I authorize the Arkansas State Board of Pharmacy to review files pertaining to this application and related documents, and all law enforcement records, administrative records, and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization for entities in possession of applicable information to release such information to the Arkansas State Board of Pharmacy.

Signature of Pharmacist in Charge: \_\_\_\_\_

Date: \_\_\_\_\_

**Send to: Arkansas State Board of Pharmacy**  
 101 East Capitol, Suite 218, Little Rock, AR 72201; Telephone: 501-682-0190  
 Website: <http://www.arkansas.gov/asbp>