Application for a Permit to Operate as an *Arkansas Hospital Pharmacy* or *Outpatient Surgery Center*

PART I: GENERAL INFORMATION			
1.	*Business Name*		
	dba or name that will appear on your permit if different from Business Name above		
2.	*Physical Address*		
Street			
City			
State		*Zip*	
Pharmacy Telephone Number		*Pharmacy Fax Number*	
Website			
3.	*Mailing Address(Complete this section ONLY if different from the physical address above)*		
Street or PO Box			
City			
State		*Zip*	
4.	*Type of Pharmacy (check all that apply)*	___ Hospital	___ Outpatient Surgery Center
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 Ownership?* *If* **Yes**, *what is the name of the facility licensed by the Arkansas Board of Pharmacy?*____ *What is the license number?*______________________ *What is the closing date of the sale?*_________________________ *Who was the previous owner?* ____________________________________	Yes [ ] No [ ]	
8.	Will you provide controlled substances? If ***Yes***, what is your Federal DEA Registration Number ?________________________ What is the Registrants name?__________________________________	Yes [ ] No [ ]	
9.	*Has the facility been inspected by the board of Health?* *If* **YES**, *what is the Board of Health license number?* ___________________ *If* **NO**, *please provide expected date of inspection* ___________________	Yes [ ] No [ ] Pending [ ]	
10.	***For hospitals only,*** *what is the number of beds licensed by the Board of Health?*		

FOR OFFICE USE ONLY

License # __________ *Date Issued:* _________ *Fee Submitted:* ________*Check No.*____________ *Permit sent*_________

11.	*Hours of Operation*		
		Please express in terms of a.m. and p.m.	*Total Hours/Day*
	Sunday		
	Monday		
	Tuesday		
	Wednesday		
	Thursday		
	Friday		
	Saturday		
		Total Hours per Week	

PART II: APPLICANT HISTORY

Please answer each of the following questions by putting a check (√) in the appropriate box on the right. You must answer each question with a "Yes" or "No" response as no other response is acceptable. All "Yes" answers MUST be explained in detail in a separate SIGNED and NOTARIZED affidavit. The affidavit should include all relevant dates, and identify the relevant jurisdiction and/or entity involved. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action. NOTE: If you answer "Yes" to any of the questions below and you have already submitted a detailed affidavit to the Arkansas State Board of Pharmacy explaining your response you need not submit another detailed affidavit. Please note the date of your previous submission next to the applicable question(s).

12.	*Is their any disciplinary action pending against the pharmacy(applicant) by any licensing jurisdiction, the USDA, Drug Enforcement Agency, or any state drug enforcement authority? If yes, please explain on a separate sheet.*	Yes [ ] No [ ]
13.	*Have any of the applicant owners, officers, directors, or stockholders ever been convicted of a felony or crime involving the practice of pharmacy? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	Yes [ ] No [ ]
14.	*Has any sanction or disciplinary action been taken regarding any license, permit or registration issued to the applicant, officers, directors, partners or stockholders involving the practice of pharmacy? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	Yes [ ] No [ ]
15.	*Are there any charges pending against the applicant, officers, directors, partners or stockholders involving the practice of pharmacy? (If the business is a corporation, you need not include stockholders in this question unless they currently serve as officers or directors of the applicant business, or own more than twenty percent (20%) of the company stock.)*	Yes [ ] No [ ]
16.	*Has the applicant ever had any application for a license or permit refused or denied by any licensing authority? If yes, please explain on a separate sheet.*	Yes [ ] No [ ]
17.	*Has the applicant ever been the subject of disciplinary action or been sanctioned by any licensing authority? If yes, please explain on a separate sheet.*	Yes [ ] No [ ]
18.	*Has the applicant ever had a registration issued by a controlled substance authority revoked, suspended, surrendered, limited, or restricted? If yes, please explain on a separate sheet.*	Yes [ ] No [ ]

PART III: PERSONNEL

19. *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.* ***YOU MUST NAME A PHARMACIST IN CHARGE.***

Name	License #	Hours/Wk	Age	Degree	Hire Date
Director of Pharmacy					
Pharmacist in charge					
Other pharmacists					
(Continued on next page.)					

Interns	License #	Hours/Wk	Hire Date

Pharmacy Technicians	Registration #	Hire Date

PART IV: BUSINESS ORGANIZATION/OWNERSHIP

20. Hospital Administrative Officer ________________________________

21. Please check one: _____Profit _____Non-Profit

22. What is your employer identification number?______________________

Select the appropriate form of ownership from the choices below, then go to the next appropriate section.

___ Sole Proprietorship (Go to 22A)
___ Corporation (Go to 22C)
___ General Partnership (Go to 22B)
___ Limited Partnership (Go to 22B)
___ LLC (Go to 22C)
___ Government, Federal
___ Government, State
___ LLP (Go to 22B)
___ Other (Please explain)

22A. Please provide the name, and the address of the owner of this company:

22B. Partnership Name, if different from Applicant name listed in Item 1, page 1.

In the space provided below, please provide the names, addresses and percentage ownership of all partners/members. You may attach a list of partners/members if there is not enough space.

Go to Item 24.

22C. Corporation Name, if different from Applicant name listed in Item 1, page 1.

____

[ ] Check if Subchapter S Corporation State of Incorporation______________________

Is this corporation publicly traded? *Yes [ ] No [ ]*
Is this corporation a wholly owned subsidiary of another company or corporation? *Yes [ ] No [ ]*
If yes, what is the name of the parent company?

If **No**, *please provide the names, addresses and percentage ownership of all of the owners of this corporation. You may use a separate sheet if you need more space.*

Go to Item 24.

23. If this is a government facility, please provide the name of the State or Agency operating this facility.

24. *Please provide the names and titles of the officers or directors of this company*

President ______________________________
Vice President ______________________________
Secretary ______________________________
Treasurer ______________________________
Specify additional titles below ______________________________

____
____
____
____

If you need additional space for the corporate officer list, please attach the list as a separate document.

PART V: OPERATIONS

25. Please respond to the following statements/questions on the bottom of this sheet and the back of it. You can attach a separate sheet if you need more space to respond, or if you wish to use a computer to record and print your responses.

    (A) Describe in detail how the pharmacy will comply with regulation 09-00-0001 – patient counseling, patient profile, drug use evaluation.
    (B) How will your pharmacy and the pharmacist in charge ensure that patient confidentiality is maintained?
    (C) **For hospitals only**, describe the computer hardware and software that will be used in the pharmacy.
    (D) If you have a website, do you provide referrals to physicians or other practitioners? Yes___ No___
    If you answered this question ***Yes***, please explain your relationship with these physicians and practitioners.

PART VI: LICENSURE

Attach copies of the following documents to this application:

(A) *A copy of the floor plan of the pharmacy showing the entrances and how it relates to other businesses in the building if it is not a free-standing building.*

(B) *A copy of your lease if you do not own the facility.*

PART VII: APPLICATION FEE *Check one of the following.*

[ ] This is a new application.
The fee for permits issued in even numbered years is $300.00
The fee for permits issued in odd-numbered years is $450.00

[ ] This is a change of ownership of a current license holder.
The fee for a change of ownership is $150.00.

NOTE: THIS APPLICATION EXPIRES 9 MONTHS FOLLOWING THE DATE OF SUBMISSION.

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 Owners/Representative: ______________________________

Print the name of the Owner/Representative: ______________________________

Position :______________________________ Date:______________________________

Signature of Pharmacist in Charge:______________________________

Print the name of the Pharmacist in Charge: ______________________________

Position :______________________________ Date:______________________________

Checks should be made payable to: *Arkansas State Board of Pharmacy.*

Return the completed application and all related documents and fees 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*