

Lawrence H. Mokhiber
Executive Secretary

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
New York State Board of Pharmacy
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Albany, NY 12234-1000
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E-mail: pharmbd@mail.nysed.gov

Department Use Only

P 4 \$345 I R

Registration Number _____

Registered as of ____ / ____ / ____

Expiration Date ____ / ____ / ____

Name Change

Relocation Change

Endorsement Date ____ / ____ / ____

Staff Processor _____

Approved Date ____ / ____ / ____

Approved by _____

PLEASE READ CAREFULLY

The New York State Board of Pharmacy must approve this application before a wholesaler registration will be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. Any application not completed within 60 days of receipt may be deemed withdrawn by the Board of Pharmacy. Fees applied to this application are not transferable and are not refundable.

PLEASE PRINT LEGIBLY OR TYPE

1 Name of pharmacy as registered in your *resident state*:

2 Trade Name/Assumed Name as registered in *resident state*:

3 Address

Street: _____

City: _____ State: _____ Zip Code: _____

4 Phone: _____ Fax: _____ E-mail: _____

5 Federal Employer ID Number: _____

6 Indicate whether this application is for:

New Pharmacy (\$345 fee) Change of Location (No Fee) Transfer of Ownership (\$345 Fee) Name Change (No Fee)
(No change in ownership)

7 If this is a *transfer of ownership, change of name* or *change of location*, indicate:

Previous Name: _____ Previous License/Permit/Registration number: _____

Previous Address: _____

8 Date of transfer of ownership or change of name or change of location:

Month: _____ Day: _____ Year: _____

9 Please indicate type of ownership:

Individual Corporation for profit LLC for profit Partnership/LLP for Profit
 Government owned Corporation not-for-profit LLC not-for-profit Partnership/LLP not-for-profit

10 Resident State: _____

Resident State License/Permit/Registration number: _____

Date Issued: _____

Expiration Date: _____

11 Companies who do business in New York State must have a registered agent for service for process in New York State, which is the contact person or agent to receive legal papers when a corporation is served for a legal reason.

Name of resident agent for service of process in New York: _____

Agent's phone number: _____

12 Pharmacy Specialty (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Community pharmacy | <input type="checkbox"/> Internet pharmacy (Include Web Site Address) http:// _____ |
| <input type="checkbox"/> Hospital pharmacy | <input type="checkbox"/> VIPPS Certified |
| <input type="checkbox"/> Infusion pharmacy | <input type="checkbox"/> Non-drug dispensing pharmacy |
| <input type="checkbox"/> Vendor pharmacy | <input type="checkbox"/> Other (Please explain) _____ |
| <input type="checkbox"/> Long term care facility pharmacy | _____ |
| <input type="checkbox"/> Mail order pharmacy (50% or more) | _____ |
| <input type="checkbox"/> Nuclear pharmacy | _____ |
| <input type="checkbox"/> Closed door pharmacy | _____ |

13 Days and hours of operation of the pharmacy: _____

14 All pre-registration correspondence should be mailed to:

- Pharmacy address indicated on page 1 of this application
- Different address** than pharmacy. *All pre-registration correspondence should be mailed to the following address.*
- Number and street: _____
- City: _____ State: _____ Zip Code: _____

15 Contact person to clarify information provided on this application:

Name: _____

Telephone: _____ Fax: _____ E-mail: _____

16 Submit Certification/Verification of License/Permit/Registration From Your Resident State

17 Non-resident pharmacies registered according to §6808B of New York State Education Law must place a toll free telephone number on a label affixed to each drug or device container.

*The Toll-Free Telephone Number for patient-pharmacist communication is: _____

*A sample prescription label must also be provided.

PLEASE
AFFIX SAMPLE
PRESCRIPTION
LABEL HERE

Members, Partners, Owners or Corporate Officers

First Name (please print)	
Last Name (please print)	
Signature	Date / /
Title (please print)	

First Name (please print)	
Last Name (please print)	
Signature	Date / /
Title (please print)	

First Name (please print)	
Last Name (please print)	
Signature	Date / /
Title (please print)	

First Name (please print)	
Last Name (please print)	
Signature	Date / /
Title (please print)	

First Name (please print)	
Last Name (please print)	
Signature	Date / /
Title (please print)	

PLEASE READ CAREFULLY

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Verification With Acknowledgment (Notarization required.)**Verification**

By signing below, I verify that the information on this application is true and accurate. I further verify that the applicant pharmacy has complied in the past and will comply in the future with all lawful requests for information from the regulatory agencies of all states in which it is licensed or registered, including New York State. I further certify that the applicant pharmacy will maintain records of drugs dispensed to patients in New York State for five years, in a manner which makes these records readily retrievable and identifiable from other business records of the pharmacy. I also verify that I have received a copy of the New York State's, "Pharmacy Guide to Practice," and I have read it and understand my responsibilities to the New York State Board of Pharmacy and the New York State Education Department. In addition, prescriptions for controlled substances shall be dispensed in accordance with Article thirty-three of the Public Health Law and Part 80 of the Department of Health's Commissioners Regulations, Article thirty-three and Part 80 can be accessed at www.health.state.ny.us/nysdoh/narcotics. Questions on controlled substances should be directed to the New York State Department of Health's Bureau of Controlled Substances at 518-402-0707.

Authorized signature (Member, Partner, Owner, Corporate Officer or Other authorized person)

Date: _____ / _____ / _____
Month Day Year

Printed Name

Title

Notary

State of _____ County of _____

On the _____ day of _____ in the year _____ before me, the above, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to this application and acknowledged to me that he/she executed the application and swore that the statements made by him/her in the application and all supporting materials are true, complete, and correct.

Notary Public signature

Notary ID number

Notary Stamp

Expiration date _____ / _____ / _____
Month Day Year

- To assure prompt filing, please be sure to complete all portions of this **application**
- Send a fee of \$345*
- Please make check or money order payable to the **New York State Education Department**. DO NOT SEND CASH. Payments made outside the United States should be made by check or draft on a United States bank in United States currency.

**New York State Education Department
Office of the Professions
Board of Pharmacy
2nd Floor West Wing
89 Washington Avenue
Albany, NY 12234**

*An application fee is required for "Registration of Pharmacy" and "Transfer of Ownership."

* NO FEE is required for Change of Location or Name Change.