

5 Pharmacy Specialty (check all that apply)

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|--|--|
| <input type="checkbox"/> Community pharmacy | <input type="checkbox"/> Prison/correctional facility pharmacy |
| <input type="checkbox"/> Hospital pharmacy | <input type="checkbox"/> Limited (Institutions only) |
| <input type="checkbox"/> Infusion pharmacy | <input type="checkbox"/> VIPPS Certified |
| <input type="checkbox"/> Vendor pharmacy | <input type="checkbox"/> Non drug dispensing pharmacy |
| <input type="checkbox"/> Long term care facility pharmacy | <input type="checkbox"/> Other (Please explain) _____ |
| <input type="checkbox"/> Mail order pharmacy (50% or more) | _____ |
| <input type="checkbox"/> Nuclear pharmacy | _____ |

6 Do you have:

- | | |
|---|--|
| A. A sink with hot & cold running water in the compounding and dispensing area? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. A separate refrigerator for storing the drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C. Basement storage? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D. A security system? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

7 Daily schedule of hours that pharmacy will be opened: (list days and hours)

Include a photo of front exterior showing **CORPORATE NAME ON EXTERIOR OF BUILDING.**

8 Pharmacy as a Separate Department: When a pharmacy is operated as a department of a larger commercial establishment, the area comprising the pharmacy shall be physically separated from the rest of the establishment, so that access to the pharmacy and drugs is not available when a pharmacist is not on duty. Identification of the area within the pharmacy by use of the words "drugs, medicines, drug stores, or pharmacy" or similar terms shall be restricted to the area licensed by the department as a pharmacy. ALL PHARMACIES MUST HAVE A MINIMUM OF 300 SQUARE FEET.

A. Will the pharmacy operate as a separate department within a larger non-registered general merchandising establishment? Yes No

B. If yes:

Name of the larger non-pharmacy business: _____

Daily schedule of business activities (days & hours): _____

Attach the following:

- Floor plan of general merchandising establishment showing location of pharmacy as closely to scale as possible. Highlight the pharmacy department.
- Photo of exterior of general merchandising establishment.
- Photo of pharmacy department – gate open.
- Photo of pharmacy department – gate closed.
- Photo of exterior sign indicating pharmacy department hours if different from general merchandising area.

9 For completion of Part II:

- Draw to scale the proposed pharmacy, indicating all dimensions. Show all doors and walls.
- Indicate areas for storage of drugs (drug bays).
- In red pen indicate **R for refrigerator**.
- In red pen indicate **S for sink** that is located in the compounding and dispensing area.
- In red pen indicate **B for bathroom** or explain location.
- Outline the registered area in yellow.
- Outline the compounding and dispensing area in another color.
- Indicate the premises adjacent to the buildings, offices and public thoroughfares.
- Name the adjacent businesses.
- **DO NOT SEND A BLUEPRINT, IT WILL BE DISCARDED.**

PART III ATTESTATION

I affirm that all information submitted to the Board of Pharmacy is true. I am familiar with the Pharmacy Handbook and the laws which govern pharmacy in New York State. I understand that pursuant to Education Law 6808(2)(e) "Every owner of a pharmacy is responsible for the strength, quality, purity and the labeling thereof of all drugs, toxic substances, devices and cosmetics, dispensed or sold, subject to the guaranty provision of this article and the public health law. Every owner of a pharmacy or every pharmacist in charge of a pharmacy shall be responsible for the proper conduct of this pharmacy. Every pharmacy shall be under the immediate supervision and management of a licensed pharmacist at all hours when open." No supervising pharmacist shall be listed as supervising pharmacist at more than one registered pharmacy at the same time.

Signature of applicant _____
*(Individual Owner, Partner, Corporate Officer, or *Other Authorized Person)* Date

Print name _____
Title

*Power of attorney must be submitted for "Other Authorized Person"

PART IV CONTACT INFORMATION

Contact Person to clarify information provided on this application:

Name: _____

Phone: _____

Fax: _____

E-mail: _____