

PH210 Pharmacy Information Form

Instructions: Complete this form and submit it to the New York State Board of Pharmacy to the address at the end of the form. Print in ink or type legibly.

Registration Number

Part I

Check what you are applying for (check one): Registration as a **FULL STORE** Registration as a **DEPARTMENT**

1. Name of owner/corporation under which registration has been issued or is sought. Enter the name exactly as it appears on your Certificate of Inc. or Articles of LLC.

2. Trade Name

3. Pharmacy Address Line 1
Line 2
Line 3
City
State ZIP Code
County

4. Complete **ONE** of the following

A. New Pharmacy Proposed date of opening mo. day yr.

B. Transfer of Ownership Proposed date of transfer mo. day yr.

Name of previous registrant _____

Registration Number _____

C. Change of Location Date of change mo. day yr.

Previous Address _____

D. Renovation Date of renovation mo. day yr.

Type of Renovation (check one)

- Full store registration to Pharmacy Department.
- Pharmacy Department to Full store registration.
- Renovation of registered area.
- Increase of registered square footage.
- Decrease of registered square footage.
- Hospitals only - Addition of new satellite area within facility.
- Other

5. Pharmacy Description: Provide a brief detailed explanation of expected day to day pharmacy operations for this establishment.

6. Do you have:

- A. A sink with hot & cold running water in the compounding and dispensing area? Yes No
- B. A separate refrigerator for storing the drugs? Yes No
- C. Basement storage? Yes No
- D. A security system? Yes 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.**

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

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 II

1. Compounding and dispensing area _____ sq. ft.

3. Indicate Scale _____ sq. ft.

2. Total registered pharmacy area _____ sq. ft.

A large grid of graph paper, consisting of 30 columns and 40 rows of small squares, intended for drawing or calculations.

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, Member or *Other Authorized Person

Date

Print Name _____

Title _____

*Power of Attorney must be submitted

Part IV

Contact person to clarify information provided on this application

Name _____

Telephone _____ Fax _____

Email _____

To assure prompt filing, please be sure you have completed all portions of this **APPLICATION** and send it to:

New York State Education Department
Board of Pharmacy
89 Washington Avenue
2nd Floor West
Albany, NY 12234-1000