The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
New York State Board of Pharmacy
E-mail: pharmbd@nysed.gov
www.op.nysed.gov/prof/pharm/

APPLICATION FOR NON-RESIDENT PHARMACY REGISTRATION IN NEW YORK STATE

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 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 Any application not completed within 60 days of receipt may be deemed withdrawn by the Board of Pharmacy.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 if within resident state)
☐ Transfer of Ownership ($345 Fee)
☐ Name Change (No change in ownership) (No Fee)

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: ____

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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: ____________________

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Pharmacy Specialty (Check all that apply)

- ☐ Community pharmacy
- ☐ Hospital pharmacy
- ☐ Infusion pharmacy
- ☐ Vendor pharmacy
- ☐ Long term care facility pharmacy
- ☐ Mail order pharmacy (50% or more)
- ☐ Nuclear pharmacy
- ☐ Closed door pharmacy
- ☐ Internet pharmacy (Include Web Site Address): ____________________
- ☐ VIPPS Certified
- ☐ Non-drug dispensing pharmacy
- ☐ Other (Please explain) ____________________

____

____

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Days and hours of operation of the pharmacy: ____________________

____

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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: ____________________

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Contact person to clarify information provided on this application:

Name: ____________________

Phone: ____________________ Fax: ____________________ E-mail: ____________________

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

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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 full corporate name and address must be on the label.

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

*A sample prescription label must also be provided.

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Members, Partners, Owners or Corporate Officers (please print)

First Name
Last Name
Title

First Name
Last Name
Title

First Name
Last Name
Title

First Name
Last Name
Title

First Name
Last Name
Title

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 verify that I am familiar with the laws, rules and regulations available at www.op.nysed.gov/prof/pharm/pharmlaw.htm; I have read them 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.ny.gov/professionals/narcotic. Questions on controlled substances should be directed to the New York State Department of Health's Bureau of Narcotic Enforcement at 518-402-0707.

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

____
Date

____
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. Change of location from one state to another requires a new application to be submitted.