Arkansas State Board of Pharmacy
322 South Main Street, Suite 600
Little Rock, AR 72201
501-682-0190 ◆ Fax 501-682-0195
www.pharmacyboard.arkansas.gov

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

PART I: GENERAL INFORMATION

Business Name:

DBA or name that will appear on your permit if different from Business Name above:

Employer Identification Number:

Physical Address of Applicant:

Street:

City: State: Zip:

Telephone Number: Fax Number:

Website:

Mailing Address (Complete this section ONLY if different from the physical address above.):

Street or PO Box:

City: State: Zip:

Person with whom the Board of Pharmacy may communicate regarding this application:

Name: Position:

Telephone: Email:

Type of Pharmacy (check all that apply):

☐ Hospital ☐ Outpatient Surgery Center
☐ Other ✳

✳Please provide a description of your operation on a separate sheet.

Controlled Substances you Plan to Provide (check all that apply):

☐ Schedule II	☐ Schedule III	☐ Schedule IV	☐ Schedule V	☐ Not Applicable
DEA Number:			☐ Applied For	☐ Not Needed
Name of DEA Registrant:				

Hours of Operation:

Day	Hours (Express in terms of a.m. and p.m.)	Total Hours / Day
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

FOR OFFICE USE ONLY

License # HP_____ Date Issued: _____ Fee Submitted: _____ Check No._____

Is this application made as a result of a change of ownership?	☐ YES ☐ NO
If **Yes**, what is the name of the facility licensed by the Arkansas Board of Pharmacy? _____	
What is the permit number? _____	
What is the expected closing date of the sale? _____	
Who was the previous owner?	
Has the facility been inspected by the Arkansas Department of Health?	☐ YES ☐ NO
If **YES**, what is the Board of Health license number? _____	
If **NO**, please provide expected date of inspection.	
For **hospitals only**, what is the number of beds licensed by the Arkansas Department of Health?	
Is this facility for profit or non-profit?	☐ For Profit ☐ Non-Profit

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).

Is the applicant currently under investigation in any state in which it is licensed?	☐ YES ☐ NO
Has the applicant ever had any application for a license or permit refused or denied by any licensing authority?	☐ YES ☐ NO
Has the applicant ever been the subject of disciplinary action or been sanctioned by any licensing authority?	☐ YES ☐ NO
Has the applicant ever had a registration issued by a controlled substance authority revoked, suspended, surrendered, limited, or restricted?	☐ YES ☐ NO
Is there any disciplinary action pending against the pharmacy (applicant) by any licensing jurisdiction, the USDA, Drug Enforcement Agency, or any state drug enforcement authority?	☐ YES ☐ NO
Has the applicant ever been convicted of violating any federal, state or local law related to drug samples, wholesale or retail drug distribution, or distribution of controlled substances?	☐ YES ☐ NO
Has the applicant ever been convicted of violating any federal, state, or local law related to the practice of pharmacy?	☐ YES ☐ NO
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
Has any sanction or disciplinary action been taken regarding any license, permit or registration issued to the applicant, officers, directors, partners or stockholders involving drug distribution? (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
Are there any charges pending against the applicant, officers, directors, partners or stockholders involving drug distribution? (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

PART III: PERSONNEL

List all individuals filling prescriptions or performing any function considered to be the practice of pharmacy for this facility. You may attach additional sheets if needed. **YOU MUST NAME A PHARMACIST IN CHARGE.**

Hospital Administrative Officer: _____

Name	License #	Hours/Week	Degree
Director of Pharmacy:			
Pharmacist in Charge:			

Other Pharmacists:			
Interns:			
Pharmacy Technicians:			

PART IV: BUSINESS ORGANIZATION/OWNERSHIP

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

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

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

Go to Item E.

B. Partnership Name, if different from Applicant name listed on 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 E.

C. Corporation Name, if different from Applicant name listed on 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 E.

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

E. 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.

V. OPERATIONS

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.

Describe in detail how the pharmacy will comply with regulation 09-00-0001 – patient counseling, patient profile, drug use evaluation.

How will your pharmacy and the pharmacist in charge ensure that patient confidentiality is maintained?

Describe the computer hardware and software that will be used in the pharmacy.		
How does your pharmacy ensure a valid patient/physician relationship?		
Does the pharmacy have a website? If **Yes**, do you provide referrals to physicians or other practitioners? If **Yes**, please explain your relationship with these physicians and practitioners.	☐ YES ☐ YES	☐ NO ☐ NO
Do you provide links to websites that provide referrals to physicians, practitioners or other organizations? If **Yes**, please describe your relationship with these other websites.	☐ YES	☐ NO
Do you process prescriptions for insurance companies and PBMs? If **Yes**, please name those companies.	☐ YES	☐ NO
Do you process prescriptions for individual patients? If **Yes**, what are your requirements for processing patient prescriptions?	☐ YES	☐ NO
Do you fill prescriptions from physicians that are contacted through the internet?	☐ YES	☐ NO
Do you have any agreements to act as a fulfillment center for any websites?	☐ YES	☐ NO
Are you are involved in any aspect of telemedicine? If Yes, please describe.	☐ YES	☐ NO

PART VI: DOCUMENTATION

Attach copies of the following documents to this application, or an explanation of why these documents are not included:

- 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.
- A copy of your lease if you do not own the facility.

PART V: APPLICATION FEE

Check **one** of the following options:

☐ This is a new permit application.
What is the date this application will be submitted to the Arkansas State Board of Pharmacy?
Add thirty days. What is the new date?_____
If this date falls in an even-numbered year (2016, 2018, etc.), the fee is $300.00
If this date falls in an odd-numbered year (2017, 2019, etc.), the fee is $450.00

☐ This is a change of ownership of a current permit holder.
The fee for a change of ownership is $150.00.

Please Note: The Arkansas Hospital Pharmacy Permit is a biennial permit and expires on December 31st of even-numbered years. If a permit is issued during an even-numbered year it will be up for renewal later that year. Check your application to make sure it is complete and you have included all required documentation. Incomplete applications will delay processing. Your application will expire 1 year from date of receipt. Application fees will not be refunded.

PART VI: 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 Owner/Representative: _____

Print the name of the Owner/Representative: _____

Position : _____ Date: _____

Signature of Pharmacist in Charge: _____

Print the name of the Pharmacist in Charge: _____

License # : _____ 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
322 South Main Street, Suite 600
Little Rock, AR 72201

Phone: 501-682-0190
Email: asbp@arkansas.gov
Website: www.pharmacyboard.arkansas.gov