



**Alabama State Board of Pharmacy
New In-State Institutional Pharmacy
Application
Permit Only \$200 Controlled Substance Fee \$300**

Date Received
Office Use Only

1. Applicant Business Details

Name of Pharmacy			
All other trade or business names ("DBA" names) used by applicant:			
Business Address: <i>Number and Street</i>			
<i>City</i>	<i>State</i>	<i>Zip</i>	<i>County (If in Alabama)</i>
Telephone Number for Business:		Federal Employer Identification Number/TIN:	
Alternate Phone Number:		Business E-mail:	
Fax Number:		DEA number:	

2. Pharmacy hours for dispensing drugs (all hours below 20 hours must be Board approved)

<i>Monday – Friday</i>	<i>Saturday</i>	<i>Sunday</i>
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3.

Give date you plan to open:	Date prescription room will be ready for inspection
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New pharmacy applications must be filed thirty (30) days prior to opening. A new pharmacy may not open until permit has been issued. At least fifteen (15) days must be allowed between above dates. (See §34-23-30 & §34-23-71, Title 34, Chapter 23, Code of Alabama 1975)

4. Supervising Pharmacist

Name	License Number:	Supervising Pharmacist Phone Number:
Supervising Pharmacist E-mail:	Tech Ratio: _____ to _____	
Are you currently employed by and working at the pharmacy? <input type="checkbox"/> Yes <input type="checkbox"/> No		

5. Compounding (Reconstituting commercially available products is not compounding)

Does this facility prepare compounds? <input type="checkbox"/> Yes <input type="checkbox"/> No (There is no "waiver" for shipping compounds into Alabama)
If yes, check all that apply: <input type="checkbox"/> Non-Sterile (795) <input type="checkbox"/> Sterile (797)
Check all that apply: <input type="checkbox"/> Clean Room <input type="checkbox"/> Nuclear <input type="checkbox"/> Specialty <input type="checkbox"/> Remote Order Entry (requires Board approval) <input type="checkbox"/> Hood <input type="checkbox"/> Parenteral <input type="checkbox"/> Veterinary

6. Suppliers

<i>Name</i>	<i>Address</i>	<i>Permit #</i>
<i>Name</i>	<i>Address</i>	<i>Permit #</i>
<i>Name</i>	<i>Address</i>	<i>Permit #</i>

7. Ownership: Ownership details must be provided for the applicant business. Include the details for the parent level ownership.

Type of Ownership:

Individual Owner
 Partnership
 Corporation (Not publicly traded)
 Publicly Traded Corporation
 Limited Liability Company

Entity Owners

If the applicant business is owned by an entity (not a natural person), the applicant must identify each parent company that has 10% or more ownership.

Entity Name	FEIN/TIN#	% of Ownership	Phone Number
Address: <i>Number and Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
Authorized Contact Person	Authorized Contact Phone Number:		

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Entity Name	FEIN/TIN#	% of Ownership	Phone Number
Address: <i>Number and Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
Authorized Contact Person	Authorized Contact Phone Number:		

Entity Name	FEIN/TIN#	% of Ownership	Phone Number
Address: <i>Number and Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
Authorized Contact Person	Authorized Contact Phone Number:		

Natural Person Ownership

Complete the details below for each owner, partner, member and/or stockholder (as appropriate) with 10% or more ownership that is a natural person owner for this business.

Name	Title	Date of Birth	Social Security Number
Address: <i>Number and Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
Phone Number	Email Address	% of Ownership	

Name	Title	Date of Birth	Social Security Number
Address: <i>Number and Street</i> <i>City</i> <i>State</i> <i>Zip</i>			
Phone Number	Email Address		% of Ownership

Name	Title	Date of Birth	Social Security Number
Address: <i>Number and Street</i> <i>City</i> <i>State</i> <i>Zip</i>			
Phone Number	Email Address		% of Ownership

Executive Officer(s):

Complete the details for each executive officer for the business. At a minimum you must include the top 3 officers.

Name	Title	Date of Birth	Social Security Number
Address: <i>Number and Street</i> <i>City</i> <i>State</i> <i>Zip</i>			
Phone Number	Email Address		

Name	Title	Date of Birth	Social Security Number
Address: <i>Number and Street</i> <i>City</i> <i>State</i> <i>Zip</i>			
Phone Number	Email Address		

Name	Title	Date of Birth	Social Security Number
Address: <i>Number and Street</i> <i>City</i> <i>State</i> <i>Zip</i>			
Phone Number	Email Address		

7. Regulatory Questions

1.	Has Applicant or any Owner, Officer, Member, Director, Manager or Partner thereof ever been arrested and/or convicted of a felony or misdemeanor, excluding minor traffic convictions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Has the applicant or any owner, officer, member, director, manager or partner thereof ever acquired, in whole or part, any interest or ownership in any pharmacy, manufacturer, wholesaler, distributor, private label distributor, repackager, 503b outsourcer, third party logistic provider and/or any other entity which may be regulated by the Board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Has any license or permit issued to any entity described in Question 2 above and/or any owner, officer, etc. thereof, ever been the subject of discipline by any pharmacy board or by any regulatory board from whom a license or permit has been issued?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has Applicant ever been denied or refused an application for a permit for a pharmacy, manufacturer, wholesaler, distributor, repackager, private label distributor, 503b outsourcer and/or third-party logistics company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Has Applicant ever withdrawn an application for a permit or surrendered license once issued to any pharmacy, manufacturer, wholesaler, distributor, repackager, private label distributor, 503b outsourcer, and/or third-party logistic company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Has any Owner, Officer, Member, Director, Manager or Partner of the Applicant ever owned in whole or in part or now owns any entity that has been denied, refused or withdrawn an application for a permit or license of a pharmacy, manufacturer, distributor, repackager, private label distributor, 503b outsourcer, and/or third-party logistics company?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Has Applicant or any Owner, Officer, Member, Director, Manager or Partner thereof ever been issued a license to practice pharmacy or as a pharmacy technician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Has an FDA 483 or Warning Letter ever been issued to Applicant or to any entity in which any Owner, Officer, Member, Director, Manager or Partner of the Applicant has been or is currently involved/affiliated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Has any final judgment ever been entered or settlement reached resulting from a claim or action for damages caused by any error, omission, or negligence in the performance of any pharmacy or pharmaceutical professional services by the Applicant or any Owner, Officer, Member, Director, Manager or Partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.	Has the applicant ever been subject to any form of discipline by any state pharmacy board or by any regulatory board from whom a license or permit had issued to the applicant?	<input type="checkbox"/> Yes <input type="checkbox"/> No

I confirm that all required information has been updated and/or submitted to the Alabama Prescription Drug Monitoring Program. (Box must be checked).

It is affirmed that all information provided herein is true and correct and it is recognized that providing false information may result in disciplinary action. It is understood that there must be compliance with the provisions of the Alabama Pharmacy Act, the Rules of the Board and all other applicable statutes and rules.

Signature of Owner, Officer, or CEO only

Title

Printed Name

Date

Are you a US Citizen? **YES** **NO** **If NO, Submit documentation of legal status in this country.**

FORM MUST BE NOTARIZED

Subscribed and sworn to before me this _____ day of _____, 20_____ A.D.

APPLICATION MUST BE NOTARIZED

Notary Public (seal)