Alabama State Board of Pharmacy
New Non-Resident Pharmacy Application
Permit Fee $750 Controlled Substance $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: *Number and Street*			
City	*State*	*Zip*	*County (If in Alabama)*
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 to AL patients (*all hours below 20 hours must be Board approved*)

Monday – Friday	*Saturday*	*Sunday*

3. Procedures

Normal turn-around time from receipt of prescriptions to shipping drugs to Alabama patients (days):
Procedure to follow by Alabama patients if medication is not available or if delivery will be delayed beyond a normal delivery time:
Procedure to follow for prescriptions for an acute illness, to include delivery at the earliest possible time (i.e. courier delivery) or alternative to assure patient the opportunity to obtain medication at the earliest possible time:
Procedure to follow when medication is not received and patient is out of medication and requires interim dosage until mailed prescription drugs become available.

4. Supervising Pharmacist (Effective 6/9/14 – Alabama Licensed SP is required. See rule 680-X-2-.07(4) (f) Mail Order Prescriptions

Name	**License Number:**	**Supervising Pharmacist Phone Number:**
Supervising Pharmacist E-mail:	**Tech Ratio:** _____ **to** _____	
Are you currently employed by and working at the pharmacy? ☐ Yes ☐ No		

(Registration with the Secretary of State is required. Go to www.sos.state.al.us for further Information)

Under the provision of the Code of Alabama §34-23-30, §34-23-31 and Board of Pharmacy regulation 680-X-2-.07, "No Non-

Resident Pharmacy shall ship, mail, or deliver prescriptions drugs and/or devices to a patient In Alabama unless registered by the Alabama State Board of Pharmacy". Please provide the policies and procedures set forth the normal delivery protocols to Alabama patients from the pharmacy providing pharmacy services.

4. Alabama Agent of Record

Name	**Phone Number:**
Address: *Number and Street*	*City* *State* *Zip*

5. Compounding

Does this facility prepare compounds? ☐ **Yes** ☐ **No** **(There is no "waiver" for shipping compounds into Alabama)**
If yes, check all that apply: ☐ **Non-Sterile (795)** ☐ **Sterile (797)**
Check all that apply: ☐ **Clean Room** ☐ **Nuclear** ☐ **Specialty** ☐ **Remote Order Entry (requires Board approval)** ☐ **Hood** ☐ **Parenteral** ☐ **Veterinary**
Does your company operate as a 503b outsourcing facility? ☐ **Yes** ☐ **No** **(If you answered "yes" you need to fill out the 503-b application on our website)**

6. 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: *Number and Street*	*City*	*State*	*Zip*
Authorized Contact Person	**Authorized Contact Phone Number:**		

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

Entity Name	**FEIN/TIN#**	**% of Ownership**	**Phone Number**
Address: *Number and Street*	*City*	*State*	*Zip*
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:	*Number and Street*	*City*	*State*	*Zip*

Phone Number	Email Address	% of Ownership

Name	Title	Date of Birth	Social Security Number

Address:	*Number and Street*	*City*	*State*	*Zip*

Phone Number	Email Address	% of Ownership

Name	Title	Date of Birth	Social Security Number

Address:	*Number and Street*	*City*	*State*	*Zip*

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:	*Number and Street*	*City*	*State*	*Zip*

Phone Number	Email Address

Name	Title	Date of Birth	Social Security Number

Address:	*Number and Street*	*City*	*State*	*Zip*

Phone Number	Email Address

Name	Title	Date of Birth	Social Security Number

Address:	*Number and Street*	*City*	*State*	*Zip*

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?**	☐ **Yes** ☐ **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**?	☐ **Yes** ☐ **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?**	☐ **Yes** ☐ **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?**	☐ **Yes** ☐ **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?**	☐ **Yes** ☐ **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?**	☐ **Yes** ☐ **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?**	☐ **Yes** ☐ **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?**	☐ **Yes** ☐ **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?**	☐ **Yes** ☐ **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?**	☐ **Yes** ☐ **No**

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)

I. Non-Resident Pharmacy Check List

All applicants must complete and submit the following documents:

☐ **Completed New Non-Resident Pharmacy Application**

☐ **Check made payable to: Alabama State Board of Pharmacy (Application fees are non-refundable)**

- New Permit Fee $750
- Controlled Substance Permit Fee $300.
- *These are two separate fees, if you need a controlled substance permit the total cost will be $1050.00*

☐ **Proof of entity (foreign or domestic) registration with the Alabama Secretary of State**. www.sos.state.al.us

☐ **DEA Certificate (copy) or Controlled Substance Waiver**

- If you are applying for a controlled substance permit you will need to provide a copy of your DEA certificate.
- All other applicants must complete the **Controlled Substance Waiver**.

☐ **Copy of Home State License for Both Pharmacy and Pharmacist**

- This must be a copy of the actual certificate.

☐ **Verification of the Home State License for Both Pharmacy and Pharmacist**

- This can be a current online verification from the home state issuing agency, but the printed verification should be within the past 30 days.
- Verifications mailed directly to our office from other regulatory agencies will not be accepted. The verification must be submitted with all other required documentation as part of the original submission.

☐ **Board Inspection Report (within the last 2 years)**

☐ **Description of Business Model/Operation and Pharmacy Type**

- A written description of all services provided at this facility.

☐ **Ownership Organizational Chart**

- Chart must show the legal business entities from the ultimate parent company down to and including the applicant and must include the legal business name, trade name, tax identification (if US company) and type of ownership for each entity on the chart. Chart must include all owner's name with a 10% or greater ownership interest in a non-publicly traded company.

☐ **Application Contact Form**

- One contact per new application only.

☐ **Discipline or any FDA 483 or FDA Warning Letter**

The following documents must be submitted for compounding.

- VPP inspection report and response (required)
- 795/797 questionnaires (on website at www.albop.com)
- List of all compounded medications (dosage form, strength, human or animal use)
- NIOSH list of meds (If applicable)
- Beyond use date policy
- Policy on testing compounds (potency, stability, sterility, & endotoxins)
- Environmental monitoring reports (to include viable and nonviable air flow)