I. Out-of-State Pharmacy Services Check List

All applicants must complete and submit the following documents:

☐ **Completed New Out-of-State Pharmacy Services Application**

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

- New Permit Fee $750

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

☐ **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**

☐ **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**

The following documents must be submitted for Policy and Procedures Manual which is required for Board Approval. (Please identify and/or label each section)

1. Hours of Operation
2. On-Call Pharmacist. For the protection of patients, when orders are being processed remotely and no pharmacist is onsite at the resident Pharmacy, a pharmacist must be on-call to respond to situations that arise that cannot be addressed through remote services, such as patient needing specific medication which is not available until the resident Pharmacy opens, or a healthcare provider urgently needing information that cannot be provided by the pharmacists performing remote order processing.
3. Procedures to be followed in case of downtime.
4. The system to be used to identify and respond to medication error arising from mistakes from remote order processing.
5. The system to be used to ensure initial and ongoing quality of remote order processing.
6. The means by which compliance with HIPAA requirement will be met.

New Out-Of-State Pharmacy Services Application **Permit Fee $750**	**Date of prior Board approval:** **Date of planned opening:** **Date Ready for Inspection:** ***For 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:**	

2. Hours open for business (*all hours below 20 hours must be Board approved*)

Monday – Friday	*Saturday*	*Sunday*

3.

Give date you plan to open:	**Date ready for inspection:**

4. Supervising Pharmacist

Name	**License Number:**	**Supervising Pharmacist Phone Number:**
Supervising Pharmacist E-mail:	**Tech Ratio, if applicable:** **_____ to _____**	

5. Pharmacy Services

Does your pharmacy plan to provide the following services? (Please note this is NOT an all-inclusive list of what the Board has the authority to consider pharmacy services.)		
1. Medication Therapy Management	YES	NO
2. Consulting	YES	NO
3. Off-site order entry (e.g., order verification, prescription data entry, etc) Please see Rule 680-X-2-.39 for full description of what is considered off-site order entry.	YES	NO

☐ I understand a pharmacy may utilize the services of an off-site order entry pharmacy if all criteria are met as set forth in Rule 680-X-2-.39(6). If utilizing off-site order entry outside these parameters, the Board shall approve only after both pharmacies present at the scheduled Board meeting.

_____ _____

Signature of Owner, Officer, or CEO only Date

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**		

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.**

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 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**
9.	**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**

FORM MUST BE NOTARIZED

Subscribed and sworn to before me this_____day of_____, 20_____A.D.
APPLICATION MUST BE NOTARIZED

_____
Notary Public (seal)