



**STATE BOARD OF PHARMACY**

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**REGISTRATION APPLICATION:  
Automated Drug Delivery System  
in Long-term Care Facility  
Form BA - 21**

**INSTRUCTIONS**

All forms must be typed, be complete, and include all supporting documentation before they will be processed by staff. This form is to be completed by a **managing pharmacy**, located and registered in Kansas, who will have an automated drug delivery system located in a long-term care facility. Please submit this form prior to the initial stocking or use of an automated drug delivery system. See K.A.R. 68-9-2(a) for definition of an automated drug delivery system.

**FEES**

For a new installation, enclose a check or money order payable to the Kansas State Board of Pharmacy in the amount of \$20.00. Fees are nonrefundable.

**Please indicate if this is a new installation or removal of automated drug delivery system:**

- New Installation Installation Date: \_\_\_\_\_
- Removal of Automated Delivery System Removal Date: \_\_\_\_\_

**MANAGING PHARMACY (Must be located and registered in Kansas)**

Name		Kansas Registration Number	
Physical Address			
City	State	Zip	County
Phone	Fax		Email
PIC Name		PIC License Number	

**LTC FACILITY RECEIVING AUTOMATED DRUG DELIVERY SYSTEM**

Name		KDADS Registration Number	
Physical Address			
City	State	Zip	County
Phone	Fax		Email

**DRUG SCHEDULES (Check all that apply for this automated drug delivery system)**

- Schedule II narcotic
- Schedule II non-narcotic
- Schedule III narcotic
- Schedule III non-narcotic
- Schedule IV
- Schedule V

If you selected any Drug Schedules above, please provide one of the following for the automated drug delivery system:

- Current DEA Registration Number \_\_\_\_\_ Expiration Date \_\_\_\_\_
- The submission date for the pending DEA Registration Application \_\_\_\_\_

**PIC CERTIFICATION**

*I declare under penalty of perjury under the laws of the State of Kansas that I am the pharmacist-in-charge acting on behalf of the applicant, and I hereby accept responsibility for operating in compliance with all state and federal laws, which shall include compliance with the Kansas Pharmacy Act and Kansas Controlled Substances Act.*

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE SIGNED

Initials: _____	<b>OFFICE USE ONLY</b>		
Permit #: _____	Fee: \$ _____	Date: _____	Check #: _____