

**STATE BOARD OF PHARMACY**

800 SW Jackson, Suite 1414
 Topeka, Kansas 66612-1244
 www.pharmacy.ks.gov (785)296-4056
 pharmacy@ks.gov Fax (785) 296-8420

REGISTRATION APPLICATION:

Third-party Logistics Provider:
 Prescription Drug, Controlled
 Substance, or Device
 Form BA-23

All applications must be typed, be complete, and include all fees and supporting documentation before they will be processed by staff.

FEES

Enclose a check or money order payable to the Kansas State Board of Pharmacy in the amount of \$350.00. Fees are nonrefundable.

REQUIREMENTS FOR NON-RESIDENT FACILITY

Attach a copy of your **current third-party logistics provider registration or permit** issued by the state of residence and the FDA, the **most recent inspection report** conducted within the past three years by the state of residence or a National Association of Boards of Pharmacy VAWD certification, a **list of registration or permit numbers** held by this facility from other states, and the **S-350 Non-Resident Information form**.

OWNERSHIP

The **Owner is the lowest level legal entity**. If the Owner is a partnership, LLC or corporation, please complete and attach the appropriate **Ownership Form** (S-310 Partnership, S-320 LLC, or S-330 Corporate). If owned by other LLCs, partnerships, holding companies, corporations, etc., please submit information down to a person level of ownership. Submit a list of all trade or business names used by the owner.

SUPPLEMENTAL INFORMATION

Please provide a **list** of all manufacturers, wholesale distributors, third-party logistics providers, outsourcing facilities, and dispensers with which the registrant is transacting business; and a **detailed explanation** of the applicant's experience in the manufacture or distribution of prescription drugs, including controlled substances.

Please indicate if this is a new application or a change:

New Application Change (Check all that apply): Address Ownership Name
 Registration number: _____ Effective date of change: _____

OWNER INFORMATION

Name			
Address			
City	State	Zip	County
Phone	Fax		Email
Ownership Type: <input type="checkbox"/> Individual Provide SSN: _____ <input type="checkbox"/> Government Entity Provide FEIN: _____ <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Corporation Complete and attach the appropriate Ownership Form (S-310 Partnership, S-320 LLC, or S-330 Corporate)			

THIRD-PARTY LOGISTICS PROVIDER INFORMATION

Name (printed on license)		Hours of Operation	
Physical Address (non-residential)			
City	State	Zip	County
Phone	Fax		Email

Initials: _____		OFFICE USE ONLY	
Permit #: _____	Fee: \$ _____	Date: _____	Check #: _____

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DESIGNATED REPRESENTATIVE INFORMATION-This should be an individual preferably located at the facility.

Name		Title		
Address				Date of Birth
City	State	Zip	County	
Phone	Fax		Email	

AUTHORIZED RESIDENT AGENT INFORMATION (Per K.A.R. 68-7-12a, must be filed with Kansas Secretary of State)

Name		Title		
Address				
City	State	Zip	County	
Phone	Fax		Email	

Designate where all formal correspondence, notices, and renewals should be sent:

- Owner Physical Location Designated Representative Authorized Resident Agent

SERVICES PROVIDED (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Prescription drugs (non-controlled) | <input type="checkbox"/> Schedule III non-narcotic |
| <input type="checkbox"/> Nonprescription drugs | <input type="checkbox"/> Schedule IV |
| <input type="checkbox"/> Schedule II narcotic | <input type="checkbox"/> Schedule V (includes pseudoephedrine, ephedrine) |
| <input type="checkbox"/> Schedule II non-narcotic | <input type="checkbox"/> Devices |
| <input type="checkbox"/> Schedule III narcotic | |

If any Drugs Schedules were selected above, please provide either:

- A copy of the current DEA Registration
Current DEA Registration Number _____ Expiration Date _____
- The submission date for the pending DEA Registration Application _____



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DISCIPLINARY INFORMATION

Applicant includes the legal ownership entity as well as each individual, owner, partner, corporate officer, director, facility manager, or designated representative.

- Yes No 1. Has the applicant been convicted under any federal, state, or local law relating to drug samples, wholesale or retail drug distribution, manufacturing, dispensing, or distribution of any drug or controlled substance?
- Yes No 2. Has the applicant been convicted of or entered a plea of no contest to any felony?
- Yes No 3. Has any license or registration, currently or previously held by the applicant been denied, disciplined, censured, revoked, suspended, or surrendered for the dispensing, manufacture or distribution of any drug or controlled substance?
- Yes No 4. Has the applicant ever furnished false or fraudulent material on any application made in connection with the dispensing, manufacture or distribution of any drug?

If yes to any of the above questions, please attach Form S-300: Disciplinary History.

- Yes No 5. Has the applicant complied with all registration requirements under any previous or current licenses or registrations?
- Yes No 6. Has the applicant complied with all requirements to maintain and make available to the Board or to any federal, state, or local law enforcement officials those records required by the Food, Drug, and Cosmetic Act?
- Yes No 7. Has each employee or associate engaged in any distribution activity had education, training, or experience sufficient for that individual to perform assigned functions in such a manner as to provide assurance that the product, quality, safety, and security will at all times be maintained as required by any federal or state law?
- Yes No 8. Has the applicant conducted a background check and fingerprinting of each facility manager and designated representative and put protections in place to ensure that no owner, designated representative, facility manager, or employee has been convicted of any felony related to prescription only drugs or devices, any felony violation of 21 U.S.C. 331, or any felony violation of 18 U.S.C. 1365 related to product tampering?

If no to any of the above questions, please attach a detailed explanation along with any relevant documentation.

DESIGNATED REPRESENTATIVE CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I understand any permit issued will be issued jointly to the applicant and myself, and I hereby accept responsibility as the designated representative for such permit, which shall include compliance with the Kansas Pharmacy Act and Kansas Controlled Substances Act and ensuring that prescription-only drugs and devices are distributed only to registered entities with the authority to possess prescription-only drugs or devices in Kansas.

SIGNATURE

DATE SIGNED

OWNER CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I have read and understand this application and that the information provided is true, correct, and complete to the best of my knowledge.

SIGNATURE

DATE SIGNED