

**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:  
Nonprescription Drugs  
Form BA-25**

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

**WHEN TO USE THIS FORM**

Use this form if you do not have a third-party logistics provider registration/permit and are providing only Nonprescription Drugs to entities other than a consumer or patient.

**FEES**

Enclose a check or money order payable to the Kansas State Board of Pharmacy in the amount of \$50.00. 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, **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 nonprescription drugs.

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

New Application      Change (Check all that apply):  Address       Ownership       Name  
Previous 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

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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

**DISCIPLINARY INFORMATION**

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

- |  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> 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?                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Has the applicant been convicted of or entered a plea of no contest to any felony?   |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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? |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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.**

- |  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Has the applicant complied with all registration requirements under any previous or current licenses or registrations?  |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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? |

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



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**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.*

\_\_\_\_\_  
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