

**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:  
Analytical Lab  
Form BA-08**

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 \$50.00. Fees are nonrefundable.

**OWNERSHIP**

The Owner is considered the "applicant" for purposes of this form. If the Owner is a corporate or other legal entity, 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, etc., please submit information down to a person level of ownership.

**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		Other States Registered (abbrev.)	
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)			

\*In accordance with K.S.A. 77-531(a)(3), Applicant consents to service via electronic mail. Service by electronic mail is complete upon transmission.

**LABORATORY INFORMATION**

Name		Researcher/Teacher Name and Title	
Physical Address			
City	State	Zip	County
Phone	Fax		Email

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

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

Initials: \_\_\_\_\_

**OFFICE USE ONLY**

Permit #: \_\_\_\_\_ Fee: \$ \_\_\_\_\_ Date: \_\_\_\_\_ Check #: \_\_\_\_\_



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**SERVICES PROVIDED** (Check all that apply)

- Schedule II narcotic
- Schedule II non-narcotic
- Schedule III narcotic
- Schedule III non-narcotic
- Schedule IV
- Schedule V
- Other: \_\_\_\_\_

If you selected any Drug Schedules 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 \_\_\_\_\_

**DISCIPLINARY INFORMATION**

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

- Yes  No 1. Has the applicant been convicted of any violation of state or federal law related to any controlled substance?
- Yes  No 2. If yes, was the conviction a felony?
- Yes  No 3. Has the applicant had any license or registration surrendered, denied, suspended, or revoked under the Kansas Uniform Controlled Substances Act?

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

**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