

**STATE BOARD OF PHARMACY**

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

REGISTRATION APPLICATION:

Retail Dealer
Form BA-10

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 \$10. Fees are nonrefundable.

OWNERSHIP

For an ownership change, please provide a document signed by both the previous owner(s) and the new owner(s) which agrees to the ownership change.

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*	

*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.

RETAIL DEALER INFORMATION

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

DESIGNATED REPRESENTATIVE INFORMATION

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

STORE PROPRIETOR/MANAGER 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

Initials: _____

OFFICE USE ONLY

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