



**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

**BUSINESS APPLICATION:  
Change in PIC  
Form BA-50**

**INSTRUCTIONS**

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

**Section A** must be completed by the outgoing PIC and submitted to and received by the Board office **within five days** of his/her last day, along with the Kansas Board of Pharmacy facility registration. Completion of this section represents sufficient compliance with K.A.R. 68-1-9. Keep a copy of the registration on display until you receive a new registration. If there is no incoming PIC, retain a copy of this form (with Section A completed) to be re-submitted when the incoming PIC is selected.

**Section B** must be completed by the incoming PIC and submitted to and received by the Board office **within 30 days** of the outgoing PIC's last day, along with payment. The new PIC's first day must be at least one day after the outgoing PIC's last day. The Board also recommends verifying that the facility email does not need to be updated.

**FEES**

Enclose a check or money order payable to the Kansas State Board of Pharmacy in the amount of \$150 for a pharmacy, \$20 for an institutional drug room, or \$350 for an outsourcing facility when **Section B** is completed. Fees are nonrefundable.

**BUSINESS INFORMATION**

Name	Kansas Registration Number
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**A. OUTGOING PIC INFORMATION** (serves as resignation notice per KAR 68-1-9)

Name	License Number
Last Day	Will you remain on staff?      Yes      No

*I understand that pursuant to K.A.R. 68-1-9 I am required to submit this notification to the Board within five days of ceasing to serve as the pharmacist-in-charge and I am responsible for conducting an inventory of all controlled substances before leaving the PIC position.*

SIGNATURE \_\_\_\_\_

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

**B. INCOMING PIC INFORMATION**

Name	License Number
First Day (Must be at least one day after outgoing PIC's last day)	Email Address

Yes    No    **Is the facility currently reporting to the K-TRACS prescription drug monitoring program? (Per KSA 65-1683, pharmacies are required to report dispensed controlled substances and other drugs of concern to K-TRACS on a daily basis). See K-TRACS.**  
If no, please complete a new K-10 form.

*I declare under penalty of perjury under the laws of the State of Kansas that I am the pharmacist-in-charge (PIC) of the facility listed on this form, and I hereby accept responsibility for ensuring that all facility operations, supervision, and personnel are in compliance with all relevant state and federal laws and regulations, which shall include the Kansas Pharmacy Act, the Kansas Controlled Substances Act, and the Kansas Prescription Monitoring Program Act; that I am responsible for all PIC duties outlined in such laws and regulations; and that pursuant to K.A.R. 68-1-9 I am responsible for conducting an inventory of all controlled substances within 72 hours of beginning to function as PIC.*

SIGNATURE \_\_\_\_\_

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

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



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**PIC WAIVER INSTRUCTIONS**

**Section C** should be completed by the owner or authorized agent and submitted to the Board office if a PIC is not able to be selected within the allotted time (30 days). Retain a copy of this form (with Sections A and C completed) to be re-submitted when the incoming PIC is selected.

Requests for additional time to secure a new PIC should be completed by the owner or authorized agent and submitted to the Board office no fewer than 20 days and no more than 30 days after the outgoing PIC's last day and should only be used when a new PIC is not able to be employed within the allotted time.

All requests for waiver are subject to review by the Executive Secretary. You will be notified of the approval or denial of your request. Requests for additional time beyond the initial waiver are subject to additional scrutiny and will be reviewed with a staff inspector.

**C. WAIVER REQUEST**

Reason for request:

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This is my:     First Request         Second Request

*I request 30 additional days in which to find a pharmacist-in-charge. I declare under penalty of perjury under the laws of the State of Kansas that I have read and understand this waiver request and that the information provided is true, correct, and complete to the best of my knowledge.*

\_\_\_\_\_  
SIGNATURE OF OWNER OR AUTHORIZED AGENT

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

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
EMAIL

**OFFICE USE ONLY**

Approved / Denied    Initials: \_\_\_\_\_    Date: \_\_\_\_\_    Notification Date: \_\_\_\_\_