

**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:
Institutional Drug Room
Form BA-12**

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 \$25.00. 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).

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.

INSTITUTIONAL DRUG ROOM INFORMATION

Name (printed on license)			
Physical Address (non-residential)			
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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DRUG SCHEDULES (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 _____

PHARMACIST-IN-CHARGE or RESPONSIBLE PRACTITIONER

Name	License Number	Hours/Week on duty in facility
Phone	Fax	Email

LICENSED PHARMACISTS (List all pharmacists working in facility. Attach additional pages if needed.)

Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number
Name	License Number

PIC or PRACTITIONER CERTIFICATION

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.

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