



**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:  
Non-Resident Pharmacy  
Form BA-22**

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 \$150.00. Fees are nonrefundable.

**APPLICATION REQUIREMENTS**

The following documents are **required** for the application to be complete:

- Copy of current registration or permit issued by state of residence
- Facility inspection report conducted within the past 18 months by state of residence or National Association of Boards of Pharmacy
- Sample prescription label
- List of other states in which registered, with permit numbers
- S-300 Disciplinary History form and explanation documents if any Discipline Information questions on page 4 of application are answered "yes".
- S-310, S-320 or S-330 ownership forms and/or business organization chart, along with supporting ownership documents (refer to top of individual forms for requirement). See Ownership information below for further detail
- S-350 Non-Resident Information form

**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 the pharmacy is owned by other LLCs, partnerships, holding companies, etc., please submit information down to a person level of ownership. Refer to K.A.R. 65-1657(b)(1).

**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			

\*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.

**PHARMACY TYPE** (Check all that apply)

- Retail – Chain       Mail Order  
 Retail – Independent       Other: \_\_\_\_\_

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

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Name			
Physical Address (non-residential, no PO Box)			
City	State	Zip	County
Phone	Fax		Email
Resident State	Registration Number	Original Issue Date	Expiration Date
Website		Can patients purchase prescriptions online? <input type="checkbox"/> Yes <input type="checkbox"/> No	NABP e-Profile ID
Toll Free Phone Number (required)		Store/Facility Hours	
Pharmacy Hours of Operation		Hours/Week Pharmacist on Duty	

**Designate where all formal correspondence, notices, and renewals should be sent:**

- 
- Owner
- 
- Physical Location
- 
- Authorized Agent

**AUTHORIZED RESIDENT AGENT INFORMATION** (Kansas licensing service company filed with Kansas Secretary of State-K.A.R. 68-7-12a)

Name		Title	
Address			
City	State	Zip	County
Phone	Fax		Email

**PHARMACIST-IN-CHARGE** (All non-resident pharmacies must have a Kansas-licensed pharmacist in charge-K.A.R.68-7-12a)

Name	Kansas License Number	Phone
Fax	Email	

 Yes     No    **Has the PIC ever been PIC at a facility currently or previously registered in Kansas?**

If yes, Pharmacy Name: \_\_\_\_\_ License Number: \_\_\_\_\_

**DRUG SCHEDULES**

If the facility holds a DEA registration, please select Drug Schedules below.

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Schedule II narcotic      | <input type="checkbox"/> Schedule IV  |
| <input type="checkbox"/> Schedule II non-narcotic  | <input type="checkbox"/> Schedule V   |
| <input type="checkbox"/> Schedule III narcotic     | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Schedule III non-narcotic |                                       |

If you selected any Drug Schedules on previous page, please provide a copy of the current DEA Registration.

Current DEA Registration Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

If you do not plan to send controlled substances into Kansas, you may be eligible for an exemption from reporting from K-TRACS. Please submit a completed K-10 K-TRACS Notice of Exemption from Reporting Form.



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**ADDITIONAL INFORMATION**

- Yes  No 1. Does the pharmacy perform any compounding?  
If yes, select all that apply:  Sterile  Non-sterile
- Yes  No 2. If the pharmacy offers any aspect of internet/digital pharmacy practice, does the pharmacy hold a Digital Pharmacy Accreditation through NABP (.pharmacy Verified Websites program)?

**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 or any pharmacist employed by the applicant been convicted of any violation of the federal Food, Drug and Cosmetic Act?
- Yes  No 2. 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?
- Yes  No 3. Has the applicant or the PIC been convicted of any felony or drug-related misdemeanor?
- Yes  No 4. Has any license or registration, currently or previously held by the applicant or the PIC been surrendered to, denied, disciplined, censured, suspended, limited, placed on probation, or revoked by any state or federal government?

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

- Yes  No 5. Has the applicant complied with all registration requirements under any previous or current licenses or registrations?

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

**LICENSED PHARMACISTS** (List all pharmacists working in the non-resident pharmacy. Attach additional pages if needed.)

Name	License Number	State
Name	License Number	State
Name	License Number	State
Name	License Number	State
Name	License Number	State
Name	License Number	State

**PIC CERTIFICATION**

*I declare under penalty of perjury under the laws of the State of Kansas that I am the pharmacist-in-charge acting on behalf of the applicant, and I hereby accept responsibility for operating in compliance with all state and federal laws, 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