

# MINNESOTA STATE BOARD OF PHARMACY

## Application To Provide Off-Site Remote Automated Distribution Pharmacy Services

(If notification is for more than one automated distribution system location, a separate form must accompany each request.)

### 1 PROVIDER PHARMACY INFORMATION

Name of the pharmacy that will be the provider for this location

License Number

Address

Telephone Number

Name of Pharmacist-In-Charge

License Number

### 2 TYPE OF REMOTE PHARMACY SERVICES

Automated Distribution System

Type

Board Approval Date

Pharmacy Policies Approval Date

### 3 REMOTE FACILITY INFORMATION

Name of the facility where services will be provided

Telephone Number

Address

Anticipated Date of Opening:

Hours of Operation:

### 4 PERSON RESPONSIBLE AT THE REMOTE FACILITY

Provide the following information for the Medical Director, Administrator, Owner, Chief Operating Officer, or Chief Executive Officer of the remote facility and attach a copy of the license.

Name

Title

You must provide a main address (confidential) and an address which may be provided to the public. You may enter the same address in both address types.   **check this box if your public address is the same as your main address**

Main Address (confidential address of record)

Home Telephone Number

Public Address (alternate address which may be provided to the public)

Public Phone Number

**5 AUTOMATED DISTRIBUTION MACHINE**

**Automated Pharmacy Systems (Attach copies of the following.)**

Documentation that the health care facility in which the automated distribution system will be located and licensed as a health care facility according to statute which means:

- (a) a nursing home licensed under section 144A.02;
- (b) a housing with services establishment registered under section 144D.01, subdivision 4, in which a home provider licensed under chapter 144A is providing centralized storage of medications; or
- (c) a community behavioral health hospital or Minnesota sex offender program facility operated by the Department of Human Services

**6 ATTESTATIONS**

**Regarding Written Contract or Agreement**

I hereby attest that the provider pharmacy and the facility have a written contract or agreement which outlines the services to be provided and the responsibilities and accountabilities of each party in fulfilling the terms of the contract or agreement in compliance with federal and state laws and regulations.

**Regarding Application**

I hereby attest that the foregoing statements, as well as those on the reverse side of this form or those on any attachment(s) to this form, are to the best of my knowledge true and correct and that they are all given of my free will. I agree to comply with the Minnesota Pharmacy Act and Rules that apply to the use of automated drug distribution systems located in health care facilities.

THESE SIGNATURES MUST BE NOTARIZED!

\_\_\_\_\_  
**Signature - Medical Director, Administrator, Owner, Chief Operating Officer, or Chief Executive Officer**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Print Name

Before me, a Notary Public, on this day personally appeared \_\_\_\_\_

known to be the person

whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purpose and consideration therein expressed. Given under my hand and seal of office this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
Notary Public, State of \_\_\_\_\_

**Additional Acknowledgement of Pharmacist-in-Charge**

I acknowledge that knowingly providing false information or omitting material facts may constitute unprofessional conduct for which the Board of Pharmacy may take disciplinary action.

\_\_\_\_\_  
**Signature - Pharmacist-in-Charge**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Print Name

Before me, a Notary Public, on this day personally \_\_\_\_\_ known to be the person  
appeared \_\_\_\_\_

whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purpose and  
consideration therein expressed. Given under my hand and seal of office  
this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

\_\_\_\_\_  
Notary Public, State  
of \_\_\_\_\_