MINNESOTA
BOARD OF PHARMACY

# Application for a Pharmacy License

LICENSE EXPIRES JUNE 30 OF EACH YEAR

**FEE FOR NEW PHARMACY AND OWNERSHIP CHANGE:** $260.00
**(NO FEE FOR REMODEL OR RELOCATION)**

**Make Check Payable to:** Minnesota Board of Pharmacy
(State of Minnesota Taxpayer Identification Number: Federal 41-6007162 - State 4405717)
**NO RETURN OR REFUND OF FEES**

**CURRENT MN LICENSE NUMBER:** ___________________

**NEW PHARMACY:** Date of proposed opening in Minnesota ______________________

**CHANGE OF OWNERSHIP:** Date of proposed change __________________________

- Former Owner ________________________________________________

**RELOCATION:** Date of proposed change ____________________________________

- Former Address ______________________________________________

**REMODEL:** Date of proposed change ________________________________________

**INSTATE ONLY:** attach copies of the plans or a sketch of the new location or a remodel.

- Make sure the plans or sketches provide the dimensions of the pharmacy and of features such as counter-tops and the counseling area.
- Amount of space being licensed: ___________ square feet.

HOURS: M-F _________ to _________ Saturday _________ to _________ Sunday _________ to ________
PHONE NUMBER: ___________________________ FAX NUMBER: ____________________________
E-MAIL ADDRESS: _________________________________________________________________

**1. Print, type, or check all applicable boxes (the physical address must be entered).**
Pharmacy Name: ______________________________________________________________
Street Address: ______________________________________________________________
City, State, Zip: _____________________________________________________________

**2. Check the appropriate item and complete ownership information:**
☐ Sole Proprietor; ☐ Partnership; ☐ Limited Liability Partnership; ☐ Corporation; ☐ Limited Liability Com.
Fill in: Name of Sole Proprietor, Partnership, or Corporation:
_________________________________________________________________
Address:_________________________________________________________________
City, State, Zip: _________________________________________________________

**Partnership or Limited Liability Partnership:** List all active and inactive partners. If a new partnership or limited liability partnership, please attach a copy of the partnership papers.

| Name | Address | RPh? | % of Ownership |
|---|---|---|---|
| | | | |
| | | | |

**Corporation or Limited Liability Company**: List voting stock shareholders and their percentage owned. List officers and their titles. For all applications or a change of ownership, please attach corporation papers (unless previously submitted to the Minnesota Board of Pharmacy).

| Name | Address | RPh? | % of Ownership |
|---|---|---|---|
| | | | |
| | | | |
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List the state of incorporation: ___________________________________________

List the number of shares of common or voting stock issued: ___________________________

**ALL PHARMACIES, IN-STATE AND OUT OF STATE MUST ANSWER THE FOLLOWING:**

**3.** Check <u>all</u> categories of licensure that apply to your pharmacy. **Note that a pharmacy also operating as an outsourcing facility must submit separate manufacturer and wholesale distributor license applications**.

☐ A. Community/Outpatient ☐ E. Nuclear ☐ I. Federal
☐ B. Hospital ☐ F. Central Service
☐ C. Home Health Care ☐ G. Veterinary
☐ D. Long Term Care ☐ H. Limited Service*

* If the limited service category is selected, no other category should be selected and you must submit a detailed description of the services that will be provided. For all other categories of licensure, submit a description of any additional services that you propose to provide.

**4. Are all prescriptions labeled and dispensed pursuant to a valid, patient specific prescription order that is received in advance of the dispensing?** ☐Yes ☐ No

**5. Will your pharmacy prepare compounded preparations? (Check each category of service that applies below, and attach a complete listing of all compounded preparations prepared by the pharmacy).**

☐ Sterile Preparation Compounding (if checked, complete 3a. & 3c. below)
☐ Nonsterile Preparation Compounding (if checked, complete 3a. & 3b. below)

**3a.** For Nonsterile & Sterile Preparation Compounding, do you follow United States Pharmacopeia (USP) 795 and USP 797 standards? ☐Yes ☐ No

**3b.** For Nonsterile Preparation Compounding, does your pharmacy prepare hazardous drugs? ☐Yes ☐ No

**3c.** For Sterile Preparation Compounding, does your pharmacy prepare high risk and/or hazardous compounded sterile preparations (CSPs)? ☐Yes ☐ No

**Or,**

☐ Sterile or non-sterile preparation compounding services will **<u>not</u>** be provided at this pharmacy (Note: per MN Rule 6800.0350, a pharmacy must receive Board approval before providing services in a license category not listed on its license).

**6. Does the owner of this pharmacy own 4 or more pharmacies under this ownership:** ☐Yes ☐ No

**7. Employees:** (Please attach another sheet if necessary)

| Pharmacist Name – Full-time and Part-time | License # | Full or part-time |
|---|---|---|
| | | |
| | | |
| | | |

| Technician Name – Full-time and Part-time | Regis. # | Full or part-time |
|---|---|---|
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**8. Please answer the following:**

(a) On behalf of the owner, if the applicant is a sole proprietorship
(b) On behalf of each partner, if the applicant is a partnership or a limited liability partnership
(c) On behalf of the corporation, if the applicant is a corporation or a limited liability company, and on behalf of each officer, director, or shareholder owning 20% or more of the voting stock of the corporation.

a. Has the applicant been convicted in any court of a felony? ☐ Yes ☐ No
b. Has the applicant habitually indulged in the illegal use of narcotics, stimulants, or depressant drugs; or habitually indulged in intoxicating liquors in a manner which could cause incompetence in the practice of pharmacy? ☐ Yes ☐ No
c. Has the applicant ever made application for a license to operate a pharmacy in this state or any other state? ☐ Yes ☐ No
   (1) If yes, was the application denied by the Board of Pharmacy? ☐ Yes ☐ No
   (2) If denied, for what reason? ________________________________________________
   (3) If the license was granted, was it later suspended, revoked, or placed on probation?
   ☐ Yes ☐ No
   (4) Did the Board, in connection with any violations, issue any warnings or reprimands?
   ☐ Yes ☐ No
   (5) If yes, what was the nature of the violation? ______________________________________
d. Has the applicant been convicted of theft of drugs or the unauthorized use, possession, or sale thereof?
   ☐ Yes ☐ No

**9.** Federal Tax ID ________________________ If MN Resident, MN Tax ID ______________________

**MINNESOTA IN-STATE PHARMACIES PLEASE COMPLETE #10 – 15.**

**10. PLEASE COMPLETE THE FOLLOWING:**

1981 Laws, Chapter 346 requires that you supply us with information concerning your worker's compensation insurance, for this firm, prior to the issuance of the license. Please check the applicable box below:

☐ Self-insured, please attach a copy of the Certificate of Exemption from the Insurance Commissioner.
☐ I DO NOT employ anyone.
☐ I HAVE paid or otherwise compensated employees, therefore, I am furnishing the following information:

Insurance Company Name: ________________________________________________
Street Address: ________________________________________________________
City, State, Zip Code: ___________________________________________________
Insurance Policy Number: ________________________________ Expiration Date: __________

**11. Does the pharmacy** have all the required equipment listed in 6800.1050? ☐ Yes ☐ No

**12.** **If this application is for a new pharmacy,** submit a scaled drawing or blueprint, indicating the following, with this application:

A. Access
B. Floor space dimensions
C. Physical security around the proposed pharmacy area
D. Location of the insulin
E. Location of prescription compounding area
F. Refrigerator
G. Location of the hypodermic syringes and needles
H. Non-Prescription area
I. Patient counseling area (with dimensions)
J. Sink
K. Location of the signs that say "Pharmacy" and/or "Drug"

**13.** **Does the applicant plan to extend drug storage/distribution to off-site locations,** i.e., emergency kits, automated drug distribution systems, etc.? ☐ Yes ☐ No If yes, please list: ____________________

**14.** **If this application is for a hospital pharmacy,** please submit the following with the application:

A. A copy of the procedure used to obtain emergency drugs, when the pharmacy is closed.
B. Samples of drug orders, prescriptions, requisitions, or other records used to order medications and filed in the pharmacy to account for drugs dispensed.

**15.** **If this application is for a hospital pharmacy,** please check the scope of services provided:
☐ Hospital in-patients ☐ Emergency out-patients ☐ Long-term care residents
☐ Other, please explain: ____________________________________________

**MINNESOTA OUT-OF-STATE PHARMACIES MUST COMPLETE #16 and #17:**

**16.** **Attach a copy of:**

a. Your current license or registration from the state in which your facility is located
b. Per MN Statute §151.19, subd. 1(f), the board shall not issue a license unless the pharmacy passes an inspection conducted by an authorized representative of the board. You must attach a copy of an inspection report issued by the appropriate regulatory authority for your state, and any related documents. The inspection must have occurred within the 24 months immediately preceding receipt of the initial application, and must be appropriate for the services provided by the pharmacy. You must also submit any FDA inspection reports issued for the pharmacy. All applicants must submit evidence that any deficiencies noted in any inspection or investigatory report have been corrected, including any documents that you have provided to state agencies or the FDA in response to inspections or investigations.

**17.**

a. Does the applicant comply with all lawful directions and requests for information from the Board of Pharmacy in all states in which it is licensed or registered? ☐ Yes ☐ No
b. Does the applicant agree to respond directly to all communications from the Minnesota Board of Pharmacy concerning emergency circumstances arising from the dispensing of drugs to residents of this state? ☐ Yes ☐ No
c. Does the applicant maintain its records of drugs dispensed to residents of Minnesota so that the records are readily retrievable from the records of other drugs dispensed? ☐ Yes ☐ No
d. Does the applicant agree to cooperate with the Minnesota Board of Pharmacy by providing information to the Board of Pharmacy of applicant's home state concerning matters related to the dispensing of drugs to residents in Minnesota? ☐ Yes ☐ No
e. Minnesota rules require a toll free telephone number to facilitate communication between patients in Minnesota and a pharmacist, who has access to the patients' records, at the pharmacy? Please provide the number. ______________________________

**ALL APPLICANTS MUST COMPLETE #18-20.**

**18.** Minnesota Statute 152.126 requires dispensers (pharmacies) licensed by the MN Board of Pharmacy to report daily to the Prescription Monitoring Program the dispensing of all schedule II-V controlled substances, butalbital and gabapentin. If no controlled substances, butalbital, or gabapentin prescriptions are dispensed on a given business day the dispenser is required to "zero report". A dispenser is **not** required to submit data for those controlled substance prescriptions distributed through the use of an automated drug distribution system according to section 151.58 or dispensed for inpatient hospital care only. If this applies to your pharmacy you are required to request an exemption from reporting. This form is located in the "PMP Data Uploader" section at: http://pmp.pharmacy.state.mn.us/index.html.

a) **Is this application for a pharmacy that will dispense controlled substance schedules II-V, gabapentin and/or butalbital in, or into the state of MN?**

☐ Yes ☐ No

*If **No**, you are required to request an exemption from reporting. This form is located at http://pmp.pharmacy.state.mn.us/index.html in the PMP data uploader section.*

**19.** **Please type or print:**
I, ______________________________, the undersigned, hereby certify that I am a licensed pharmacist in the state of ____________________, holding License Number ________________, and that I have been designated as Pharmacist-in-charge of the pharmacy named in this application and I do hereby assume professional responsibility for said pharmacy as the Pharmacist-in-charge (PIC).

_______________________________________ ______________

Signature of the Pharmacist-in-charge Date

I will be the permanent PIC: ☐ Yes ☐ No (If you answer 'No' and are not the permanent PIC, a permanent PIC must be designated prior to issuance of the license).

**20.** **The data you supply on this form will be used to assess your qualifications for licensure.** You are not legally required to provide this data, but we will not be able to grant the license without it. This data will constitute a public record, if and when the licensure is granted, and, at that time, copies may be issued to anyone.

I have read the above statement and I agree to supply the data on this form with full knowledge of the information provided in that statement. In addition, I, the undersigned, do hereby certify that all of the information contained in this application is true and correct and that the firm will be operated in compliance with all applicable laws and regulations.

| **Name and title of applicant**<br>Please type or print | **Signature** of Applicant, Owner, Partner<br>or Administrative Officer | **Date** |
|---|---|---|
| | | |