DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF PHARMACY
4052 BALD CYPRESS WAY, BIN #C-04
TALLAHASSEE, FLORIDA 32399-3254
(850) 245-4292

NON-RESIDENT PHARMACY APPLICATION AND INFORMATION

November 2012

DH-MQA 1217, 11/12
Rule 64B16-28.100, F.A.C.

Dear Florida Pharmacy Permit Applicant,

Thank you for applying for a pharmacy permit in the State of Florida. The information in this packet is designed to provide the essential information required to process your application in a timely manner. Your assistance in providing all required information will enable the Florida Board of Pharmacy (The Board) staff to process your application as soon as possible. You are encouraged to apply as early as possible, to avoid delays due to a large volume of applicants.

Florida Statutes require a completed application and fees before your application can be approved. Please read these instructions carefully and fully before submitting the application. You should keep a copy of the completed application and all other materials sent to the board office for your records. When you mail the completed application and fees, use the address noted in the instructions and on the application form.

When your application arrives, your fees will be deposited and verified before the staff review will begin. You will receive a letter acknowledging receipt of your application and the status of the application within 30 days of receipt.

If you need to communicate with the board staff, you are encouraged to email the board staff at mqa_pharmacy@doh.state.fl.us, or you may at call us at (850) 245-4292. Our staff is committed to providing prompt and reliable information to our customers. We certainly welcome your comments on how our services may be improved by completing our Customer Survey at http://survey.doh.state.fl.us/survey/entry.jsp?id=1224772782379.

Sincerely,

The Board of Pharmacy

Non-Resident Pharmacy Permit Application Information

Whether opening a new establishment, changing locations, or changing owners, a pharmacy permit is required prior to operating in the State of Florida. The permit application must be completed and returned to the Florida Board of Pharmacy with the required fee of $255.00. The application must have the original signatures of the owner or officer of the establishment and the Prescription Department Manager (PDM) or Pharmacist in Charge.

Non-Resident Pharmacy Registration as authorized by Section 465.0156, F.S., is required for those pharmacies located outside the state and which ships, mails, or delivers a dispensed medicinal drug into this state. In order to dispense medicinal drugs into Florida, the pharmacy and the pharmacist designated as the prescription department manager or equivalent must be licensed in the state of location. You must provide a toll free number which is available 6 days a week, not less than 40 hours and the pharmacist is able access the patient records.

Application Processing

Please read all application instructions before completing your application.

1) Please mail the application and the $255.00 application fee (check or money order made payable to the FLORIDA DEPARTMENT OF HEALTH) to the following address:

   Department of Health
   Board of Pharmacy
   P.O. Box 6320
   Tallahassee, Florida 32314-6320

   OR, use the following address if you are using express mail:

   Department of Health
   Board of Pharmacy
   4052 Bald Cypress Way, Bin C-04
   Tallahassee, FL 32399-3254

2) Please submit a letter of licensure verification for the facility as well as for the Pharmacy Manager from the state board of pharmacy where you are located. The letter must include:
   a. Original Licensure Date;
   b. Expiration Date; and
   c. Licensure Status.

3) Please submit a copy of your most recent inspection by the state board of pharmacy or the entity responsible for conducting inspections in the state where you are physically located.

Within 30 days of receipt of your application and fees, the board office will notify you of the receipt of your application, any required documents, and your status. If your application is incomplete, you will be notified in writing of what is required to deem your application complete.

FLORIDA BOARD OF PHARMACY
P.O. Box 6320
Tallahassee, FL 32314-6320
Telephone (850) 488-0595
http://www.doh.state.fl.us/mqa/pharmacy

NON-RESIDENT PHARMACY REGISTRATION

Application Type – Please choose one of the following:

____ New Establishment ($255.00 Fee)
____ Change of Location ($100.00 Fee)
____ Change of Ownership (a new permit number will be issued) ($255.00 Fee)
If applicable, list existing permit number: _____

List Federal Employer Identification Number:

1. Corporate Name	**Telephone Number**
2. Doing Business As (d/b/a)	**E-Mail Address**

3. Mailing Address		
City	**State**	**Zip**

4. Physical Address		
City	**State**	**Zip**

5. List Prescription Department Manager (PDM)

Name	**License No.**	**Start Date**	**Signature**

6. Contact Person	**Telephone Number**
7. DEA Registration Number	**8. Do you have 24 hour access to patient records?**
	____YES ____NO If no explain on separate sheet

9. Please provide the name, address, telephone number, and permit number of your prescription drug wholesale distributor.

Name	**Telephone Number**	**Permit Number**	
Street Address	**City**	**State**	**Zip**

10. Operating Hours	**10a. Provide the Toll-Free Telephone number available six days a week for 40 hours below:**
Prescription Department Hours Monday-Friday: Open _____ Close: _____ Saturday: Open: _____ Close: _____ Sunday: Open: _____ Close: _____	(_____) _____- _____

11. Ownership Information

a. Type of Ownership: _____Individual _____Corporation _____Partnership

_____Other: _____

NOTE: IF CORPORATION OR LIMITED PARTNERSHIP YOU MUST INCLUDE WITH YOUR APPLICATION A COPY OF THE ARTICLES OF INCORPORATION ON FILE WITH THE SECRETARY OF STATE'S OFFICE WHERE THE PHARMACY IS LOCATED.

b. Are the applicants, officers, directors, shareholders, members and partners over the age of 18?

Yes _____ No _____

c. List each person having an ownership interest of 5 percent or greater and any person who, directly or indirectly, manages, oversees, or controls the operation of the applicant ***Attach a separate sheet if necessary.***

Owner/Officer-Title	Date of Birth	Mailing Address	% of Ownership

Pursuant to Section 456.0635(2), *Florida Statutes*, questions 12 through 18 must be answered. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

12. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss.1395-1396? (If no, do not answer 13.)

Yes _____ No _____

(You must include all misdemeanors and felonies, even if adjudication was withheld by the court, so that you would not have a record of conviction. Driving under the influence or driving while impaired is NOT a minor traffic offense for the purposes of this question.)

13. If "yes" to 12, for the felonies of the first or second degree, has it been more than 15 years from the date of the plea, sentence and completion of any subsequent probation?

Yes _____ No _____

13a. If "yes" to 12, for the felonies of the third degree, has it been more than 10 years from the date of the plea, sentence and completion of any subsequent probation? (This question does not apply to felonies of the third degree under Section 893.13(6)(a), Florida Statutes).

Yes _____ No _____

13b. If "yes" to 12, for the felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years from the date of the plea, sentence and completion of any subsequent probation?

Yes_____ No_____

13c. If "yes" to 12, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant successfully completed a drug court program that resulted in the plea for the felony offense being withdrawn or the charges dismissed? (If "yes", please provide supporting documentation).

Yes _____ No_____

14. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 15.)

Yes _____ No _____

15. If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated, has the applicant been reinstated and in good standing with the Florida Medicaid Program for the most recent five years?

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

16. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 17 and 18)

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

17. Has the applicant been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

18. Did the termination occur at least 20 years prior to the date of this application?

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

19. Are you currently registered or permitted in any other states? If yes, provide the state, permit type, and permit number for each permit. *Attach a separate sheet if necessary.*

Yes _____ No _____

State	Permit Type	Permit Number

20. Has the applicant, affiliated persons, partners, officer, directors, or PDM or Consultant Pharmacist of Record ever owned a pharmacy? If yes, provide the name of the pharmacy, the state where the pharmacy is located and the status of the pharmacy. *Attach a separate sheet if necessary.*

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

Pharmacy Name	State	Status

21. Has any disciplinary action ever been taken against any license, permit or registration issued to the applicant, affiliated persons, partners, officers, directors or PDM in this state or any other?

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

22. Is there any other permit issued by the Florida Department of Health located at the physical location address on this application?

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

23. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

Yes_____ No_____

ALL QUESTIONS MUST BE ANSWERED OR YOUR APPLICATION WILL BE RETURNED

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Section 456.013(1), F.S., requires that applicants supplement their applications as needed to reflect any material change in any circumstances or conditions stated in the application, which takes place between the initial filing of the application and the final grant or denial of the license, which might affect the decision of the department.

I certify that the statements contained in this application are true, complete, and correct and I agree that said statements shall form the basis of my application and I do authorize the Florida Board of Pharmacy to make any investigations that they deem appropriate and to secure any additional information concerning me, and I further authorize them to furnish any information they may have or have in the future concerning me to any person, corporation, institution, association, board, or any municipal, county, state, or federal governmental agencies or units, and I understand according to the Florida Board of Pharmacy Statutes that a Pharmacy Permit may be revoked or suspended for presenting any false, fraudulent, or forged statement, certificate, diploma, or other thing, in connection with an application for a license or permit, as set forth in Section 465.015(2)(a), F.S.

Under penalty of perjury I have read the foregoing document and that the facts stated in it are true. I recognize that providing false information may result in disciplinary action against my license or criminal penalties.

SIGNATURE _____ TITLE _____DATE_____
Owner/Officer

PHARMACY PERMIT APPLICATION CHECKLIST

Keep a copy of the completed application for your records.

It is recommended that you use the following checklist to help ensure that your application is complete. Failure to attach any required document, or to have required documentation sent to the Board, will result in an incomplete application. Faxed applications will not be accepted.

NON-RESIDENT PHARMACY PERMIT

_____ **Application Completed (all questions answered)**

_____ **Application signed**

_____ **Pharmacy Manager or Consultant Listed with Signature**

_____ **Pharmacy Manager and Pharmacy License Verification from the resident state**

_____ **$255.00 Fee Attached (Permit fee includes $250 application fee and $5.00 unlicensed activity fee)**

_____ **Certificate of Status for the Corporation from the Secretary of State**

_____ **Bill of Sale is required for Change of Ownership**

_____ **Recent Inspection Report**