TEXAS STATE BOARD OF PHARMACY

333 Guadalupe Street, Suite 3-500 Austin, Texas 78701
512-305-8000 ★ www.pharmacy.texas.gov

Hospital/Ambulatory Surgical Center Pharmacy (Class C) License Application

Type or clearly print (all blanks must be complete – if not applicable, enter N/A)

1 Pharmacy Information

Legal Name (Corp, LLC, etc):

Pharmacy Name:

Street Address: Ste:

City/State/ Zip:

2 Pharmacy Telephone Number

( )

Pharmacy Fax Number :

( )

Web Address:

Email Address:

3 Type of Ownership (check one)

- ☐ Corporation
- ☐ Limited Liability Company (LLC)
- ☐ Government
- ☐ Partnership
- ☐ Individual
- ☐ Other (specify) _____

4 Type of Pharmacy (check one)

- ☐ Hospital (Independent) - _____# licensed beds
- ☐ Hospital (Multiple/Chain ≥5) - _____# licensed beds
- ☐ Ambulatory Surgical Center
- ☐ Other (specify) _____

8 Pharmacist-in-Charge **TX License**

_____ _____

(Print or type)

9 By my signature, I acknowledge I am the pharmacist-in-charge of this pharmacy and attest that I have read and understand the laws and rules relating to this class of pharmacy.

THIS SIGNATURE MUST BE NOTARIZED

_____ _____

Signature of Pharmacist-in-Charge Date

10 Subscribed and sworn to before me this _____

day of _____ , 20 _____

_____

Notary Public

FOR TSBP USE ONLY

File #	Entity #	Application #	TransCode#
Amount Recv'd	**License #**	**AFL Date**	

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- ☐ **Check here if for a *NEW PHARMACY***
- ☐ **Check here if a *CHANGE OF OWNERSHIP*.**

If change of ownership, indicate previous information below:

Current Pharmacy License Number: _____

Legal Name (Corp, LLC, etc):

Pharmacy Name:

Street Address: Ste:

City/State/ Zip:

6 Application Fee Payable to Texas State Board of Pharmacy

Pharmacy License **$507**

# of Pharmacy Balances/Scales _____ **x $25.00** **$** _____

TOTAL DUE **$**

7 Description of Services – Check All That Apply
Must Indicate at Least 1 Type of Service

- ☐ 24 Hour Service
- ☐ Closed Door
- ☐ Compounding Sterile, LOW Risk
- ☐ Compounding Sterile, MED Risk
- ☐ Compounding Sterile, HIGH Risk
- ☐ Compounding, Non-Sterile*
- ☐ Compounding, Office Use
- ☐ Home Delivery
- ☐ Infusion
- ☐ Inpatient Prescriptions
- ☐ Nuclear
- ☐ Out Patient Prescriptions
- ☐ Out Patient Surgery
- ☐ Pharmacist Administered Immunizations
- ☐ Shipping Prescriptions Out-of-State
- ☐ Veterinary Prescriptions
- ☐ Other: _____

11 Anticipated Date of Opening | **Hours of Operation:**

12 Staff Pharmacist(s) **License #**

13 Registered Technician(s) **Registration #**

***Do not check this service if the pharmacy is only reconstituting a manufacturer's NON-STERILE product (e.g., reconstituting an antibiotic suspension).**

Hospital/Ambulatory Surgical Center Pharmacy (Class C) License Application (Continued)

Type or clearly print (all blanks must be complete – if not applicable, enter N/A)

14 PROVIDE INFORMATION REGARDING TEXAS DEPARTMENT OF STATE HEALTH SERVICES

(a) Enter the applicable Texas License Number in the space provided:
Department of State Health Services (DSHS)/Health & Human Services Commission (HHSC)
Hospital License No: _____
DSHS/HHSC Inpatient Hospice License No: _____ DSHS/HHSC Ambulatory Surgical Center License No: _____

(b) Is the facility an inpatient hospital maintained/operated by the State of Texas? _____

(c) If the pharmacy is operated by a hospital/pharmacy management company, provide te name of the management company and attach a copy of the services agreetment. Name of management company:_____

15 PRIMARY OWNER OR ONE OF THE MANAGING OFFICERS MUST ANSWER THE FOLLOWING QUESTIONS:

1. Has the pharmacy, or the corporation, partnership, or other entity that owns the pharmacy, been the subject of any professional disciplinary action or are any such actions pending against this entity by a regulatory authority? (Examples: surrender, revocation, reinstatement, suspension, fine, probation, restriction). Include such information for all states, including Texas, and for all regulated professions. ☐ YES* ☐ NO

***If you answered "yes" to Question #1, include the name of the Board, licensing or disciplinary authority and the date of the Order, and, if applicable, the date of the termination of the condition and/or probation.**

2. Has the pharmacy, or the corporation, partnership, or other entity that owns the pharmacy, been subject to court ordered probation as related to any offense? ☐ YES ☐ NO

3. Are the customer service areas of the Pharmacy accessible to disabled persons, as defined by federal law? ☐ YES ☐ NO

4. Does the pharmacy provide translating services for customers, including translating services for a person with impairment of hearing? If yes, what type of translating services does the pharmacy provide? (check all that apply): ☐ YES ☐ NO

☐ 1 Spanish ☐ 3 Telecommunication Device for the Deaf (TDD) ☐ 5 AT&T Translating Service
☐ 2 Vietnamese ☐ 4 American Sign Language ☐ 6 Other_____

5. Does this pharmacy participate in the Texas Medicaid program? ☐ YES ☐ NO

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ATTEST: I hereby attest that the foregoing statements, on 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 that any misstatement(s) or omission(s) as to material facts will constitute violation of and subject me to the penalties set forth in the Texas Pharmacy Act. I agree to comply with the Texas Pharmacy Act and Rules.

THIS SIGNATURE MUST BE NOTARIZED:

_____ _____ Subscribed and sworn to before me this _____ day
Signature of Owner / Managing Officer Date of _____, 20 ____

_____ _____
Owner / Managing Officer's Name (Type or Print) Notary Public