TEXAS STATE BOARD OF PHARMACY

333 Guadalupe Street, Suite 3-600 Austin, Texas 78701
512-305-8000 ✯ www.pharmacy.texas.gov

Clinic Pharmacy (Class D) License Application

1 Pharmacy Name & Location Address (Street, City, 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)

- ☐ Public Health
- ☐ Other (specify) _____

8 Pharmacist-in-Charge 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

License No.	Amount	Receipt No.	Applicant No.

5

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

If change of ownership, indicate previous name, address and license number of pharmacy:

_____
_____
_____

6 Application Fee Payable to Texas State Board of Pharmacy

Pharmacy License $454

# of Pharmacy Balances/Scales _____ x $25.00 $

TOTAL DUE $

7 Description of Services – Check All That Apply

- ☐ Alternative Visitation Schedule
- ☐ Expanded Formulary
- ☐ Home Delivery
- ☐ Other (specify below):

11 Anticipated Date of Opening and Hours of Operation:

12 Staff Pharmacist(s) License #

_____
_____
_____
_____

13 Registered Technician(s) Registration #

_____
_____
_____
_____
_____
_____

NOTICE: A Class D pharmacy license shall not be issued to a physician's office.
Texas State Board of Pharmacy Rules define Clinic Pharmacy (Class D) as a facility/location other than a physician's office, where limited types of dangerous drugs or devices restricted to those listed in and approved for the clinic's formulary are stored, administered, provided, or dispensed to outpatients. (e.g. planned parenthood, public health).
Read Rule 291.93.

14 Class D Clinic Pharmacy

(a) Name and Texas License Number of Medical Director:_____

(b) Attach a copy of the Pharmacy's Policy and Procedure Manual, which must include the clinic drug formulary if requesting permission to maintain an expanded formulary or an alternative visitation schedule, see Board Rule 291.93.

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

6. Does this pharmacy participate in the Texas State Kids Insurance Program (SKIP)? ☐ YES ☐ NO

16 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:

_____ Signature of Owner / Managing Officer

_____ Date

Subscribed and sworn to before me this _____ day of _____, 20 _____

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

_____ Notary Public