



# TEXAS STATE BOARD OF PHARMACY

333 Guadalupe Street, Suite 3-600 Austin, Texas 78701

512-305-8000 512-305-8075(fax)

## Hospital Pharmacy Compounding Sterile Preparations (Class C-S) License Application

<b>1</b>	Pharmacy Name & Location Address (Street, City, ZIP)	<b>FOR TSBP USE ONLY</b>			
	Name:	License No.	Amount	Receipt No.	Applicant No.
	DBA Name:				
	Address:	<b>5</b> <input type="checkbox"/> Check here if for a <i>NEW PHARMACY</i> <input type="checkbox"/> Check here if a <i>CHANGE OF OWNERSHIP</i> .  If change of ownership, indicate previous name, address and license number of pharmacy: _____ _____ _____			
	City/State/Zip				
<b>2</b>	Pharmacy Telephone Number:				
	( )				
	Pharmacy Fax Number :				
	( )				
	Web Address:				
	Email Address:				
<b>3</b>	Type of Ownership (check one)	<b>6</b> Application Fee Payable to Texas State Board of Pharmacy			
	<input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company (LLC) <input type="checkbox"/> Government <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Other (specify) _____	Pharmacy License <span style="float: right;">\$454</span> # of Pharmacy Balances/Scales _____ x \$25.00 \$ <b>TOTAL DUE \$</b>			
<b>4</b>	Type of Pharmacy (check one)	<b>7</b> Description of Services – Check All That Apply Must Indicate at Least 1 Type of Service			
	<input type="checkbox"/> Hospital (Independent) -- _____# licensed beds <input type="checkbox"/> Hospital (Multiple/Chain ≥5) -- _____# licensed beds <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> 24 Hour Service <input type="checkbox"/> Home Delivery <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Nuclear <input type="checkbox"/> Compounding Sterile, LOW Risk <input type="checkbox"/> Out Patient Prescriptions <input type="checkbox"/> Compounding Sterile, MED Risk <input type="checkbox"/> Out Patient Surgery <input type="checkbox"/> Compounding Sterile, HIGH Risk <input type="checkbox"/> Pharmacist Administered Immunizations <input type="checkbox"/> <b>Compounding, Non-Sterile*</b> <input type="checkbox"/> Compounding, Office Use <input type="checkbox"/> Shipping Prescriptions Out-of-State			
<b>8</b>	Pharmacist-in-Charge	License #	<b>11</b> Anticipated Date of Opening and Hours of Operation:		
	_____	_____			
	(Print or type)				
<b>9</b>	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. <b>THIS SIGNATURE MUST BE NOTARIZED</b>		<b>12</b> Staff Pharmacist(s) License #		
	_____ Signature of Pharmacist-in-Charge      Date		_____ _____ _____		
<b>10</b>	Subscribed and sworn to before me this _____ day of _____, 20____		<b>13</b> Registered Technician(s) Registration #		
	_____ Notary Public		_____ _____ _____		

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

