TEXAS STATE BOARD OF PHARMACY

333 Guadalupe Street, Ste. 3-600 ✯ Austin, Texas 78701
512-305-8021 ✯ 512-305-8082 (fax) ✯ www.tsbp.state.tx.us

INSTRUCTIONS FOR FILING CLASS D PHARMACY APPLICATION

IMPORTANT: Read and follow these instructions completely. Failure to submit the necessary items will delay the processing of your application. You will be notified of any deficiencies in your application within 2 to 4 weeks of receipt.

Allow a *minimum of 90 days* from the time your application packet is complete, to process your application. Any forms that have been previously submitted with another application will not be pulled from the file. You must complete and submit all of the requested information. If the application process is not completed within one year from the application receipt date, the application will be withdrawn. **NOTE: if a change in officer, owner, or location occurs while the completed application is under review by TSBP, the application will be cancelled and a new application packet, including application fee, must be submitted.**

CHECKLIST FOR FILING D PHARMACY LICENSE APPLICATION

☐ 1. Application Form (*LIC-001 see form attached below)*

☐ 2. Ownership Form
- Partnership or individual *(form # LIC-006), **OR***
- Corporation or Limited Liability Company *(form # LIC-007), **OR***
- Government owned *(form # LIC-008)*

☐ 3. Lease Agreement/Property Ownership
Copy of lease agreement between the owner of the pharmacy and the owner of the building in which the pharmacy is located. In cases where the real property is owned by the pharmacy license holder, a notarized statement to that effect signed by the owner, must be submitted *(form # LIC-004).(Form LIC-004 is NOT considered a lease agreement*

☐ 4. New Pharmacy Checklist, (form # *LIC-018*). The form lists the minimum infrastructure requirements needed to apply for a new pharmacy license and must be submitted with a New Pharmacy Application.

☐ 5. Attach a copy of the Pharmacy's Policy and Procedure Manual which must include the clinic drug formulary. (Note: If you are applying for permission to maintain an expanded formulary or to use an alternative visitation schedule, see Board Rule 291.93).

TEXAS PHARMACY LICENSE APPLICATION (Class A, B, C, D)

Please type or print.

1 Pharmacy Name & Physical Location Address (Street, City, State, ZIP)

Pharmacy Tel:

FOR TSBP USE ONLY

License No.	Amount	Receipt No.	Entity No.

2 Physical Location above also the Mailing Address? ☐ YES ☐ NO

If no, provide a mailing address (Street, City, State, ZIP)

3 ☐ 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:

4 Class of Pharmacy *(check one)*

- ☐ A Community
- ☐ B Nuclear
- ☐ C Institutional (Hospital)
- ☐ D Clinic

5 Type of Ownership *(check one)*

- ☐ 1 Corporation
- ☐ 2 Government
- ☐ 3 Individual
- ☐ 4 Partnership
- ☐ 5 Other (specify) _____

6 Pharmacy License Fee— $ 535.00

# of Pharmacy Balances _____ x $25.00 $ _____

TOTAL DUE $

7 Services *(check ALL that apply)*

- ☐ 1 Nuclear
- ☐ 2 Out-Patient Sterile Products (Hospital)
- ☐ 3 Out-Patient/Discharge Prescriptions
- ☐ 4 Mail Service
- ☐ 5 Long Term Care
- ☐ 6 Class D (Expanded Formulary)
- ☐ 7 Class D (Alternative Visit Schedule)
- ☐ 8 Compounding Sterile, Risk Level LOW
- ☐ 9 Compounding Sterile, Risk Level MED.
- ☐ 10 Compounding Sterile, Risk Level HIGH
- ☐ 11 Compounding, Non-Sterile

8 Type of Pharmacy *(check one)*

- ☐ 1 Community (Independent)
- ☐ 2 Community (Multiple/Chain ≥ 5)
- ☐ 3 Hospital (Independent) # licensed beds _____
- ☐ 4 Hospital (Multiple/Chain ≥ 5) # licensed beds _____
- ☐ 5 Ambulatory Surgical Center
- ☐ 6 HMO
- ☐ 7 Public Health
- ☐ 8 Mail Service
- ☐ 9 Internet Pharmacy
- ☐ 10 Other (Specify)

9 Pharmacist-in-Charge _____ License # _____

(Print or type)

10 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

Subscribed and sworn to before me this

day of _____ , 20 _____

Notary Public _____

11 Anticipated Date of Opening and Hours of Operation:

a. _____

b. Description of Services Offered (or attach a copy of your business plan):

12 Other Pharmacists and Registered Technicians — License # or Registration #

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

CLASS B, CLASS C, OR CLASS D PHARMACY LICENSE

13 Complete the following, if applicable.

Nuclear (Class B) Pharmacy

(a) Texas Department of Health Radiation Control No. _____

(b) Attach: (1) Detailed copy of the floor plan for the Class B Pharmacy; and

(2) Qualifications of the authorized nuclear pharmacist who is the pharmacist-in-charge.

Institutional (Class C) Pharmacy

(a) Enter the Applicable Texas License Number in the space provided:

DSHS Hospital License No# _____ DSHS Ambulatory Surgical Center License No# _____

DSHS Inpatient Hospice License No# _____

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

(c) Is the pharmacy owned/operated by a hospital management or hospital pharmacy management firm? _____

If YES, provide the name of the firm here: _____ and attach a copy of the service agreement.

Clinic (Class D) Pharmacy

(a) Name and Texas License of the staff physician: _____

(b) Attach a copy of the Pharmacy's Policy and Procedure Manual, which must include the clinic drug formulary. (Note: If you are applying for permission to maintain an expanded formulary or to use an alternative visitation schedule, see Board Rule 291.93.)

14 **ALL APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS:**

1. Has the pharmacy, the pharmacy's owner or any officer or partner (if the pharmacy is owned by a corporation or partnership) been the subject of any professional disciplinary action or are any such actions pending against you 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. Response must include the name of the person who was the subject of the disciplinary action.

2. For any criminal offense, including those pending appeal, has the pharmacy, the pharmacy's owner or any officer or partner (if the pharmacy is owned by a corporation or partnership):

A.	been arrested?	☐ YES*	☐ NO
B.	been charged with a crime but not arrested?	☐ YES*	☐ NO
C.	pled nolo contendere?	☐ YES*	☐ NO
D.	pled guilty?	☐ YES*	☐ NO
E.	received deferred adjudication for a misdemeanor?	☐ YES*	☐ NO
F.	received deferred adjudication for a felony?	☐ YES*	☐ NO
G.	been convicted of a misdemeanor?	☐ YES*	☐ NO
H	been convicted of a felony?	☐ YES*	☐ NO

In answering Questions #2A-H, include all offenses even those for which you were subject to deferred adjudication. (Examples: assault, theft, possession of controlled substances, public intoxication, DWI, driving under the influence of drugs.) Response must include the name of the person who was the subject of the disciplinary action.

3. Has the pharmacy, the pharmacy's owner or any officer or partner (if the pharmacy is owned by a corporation or partnership) been subject to a court ordered probation or confinement as related to any offense? ☐ YES* ☐ NO

4. Has the pharmacy, the pharmacy's owner or any officer or partner (if the pharmacy is owned by a corporation or partnership) served time in prison for any offense? ☐ YES* ☐ NO

5. Has the pharmacy, the pharmacy's owner or any officer or partner (if the pharmacy is owned by a corporation or partnership) been convicted of a drug or alcohol related offense, or been subject to a deferred adjudication for this offense? (Examples: possession of controlled substances, public intoxication, DWI, driving under the influence of drugs.) ☐ YES* ☐ NO

*If you answered "yes" to Questions #3-5, include the name and location of the court, the offense charged, a brief explanation of the offense, the date of action, and, if applicable, the date that probation or confinement ended. Response must include the name of the person who was the subject of the disciplinary action.

6. Is the pharmacy's owner or any other officer or partner a registered sex offender in Texas or in any other State? ☐ YES* ☐ NO

If you answered "yes", include the name of the person who is registered.

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

8. Does the pharmacy provide translating services for customers, including translating services for a person with impairment of hearing? ☐ YES ☐ NO

If yes, what type of translating services does the pharmacy provide? (check all that apply):

☐ 1 Spanish ☐ 3 Telecommunication Device for the Deaf (TDD) ☐ 5 AT&T Translating Service

☐ 2 Vietnamese ☐ 4 American Sign Language ☐ 6 Other_____

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

10.	Does this pharmacy participate in the Texas State Kids Insurance Program (SKIP)?	☐ YES	☐ NO
11.	Does this pharmacy dispense a prescription drug or device under a prescription drug order in response to a request received by the way of the internet to dispense the drug or device?	☐ YES	☐ NO
12.	If the response to the previous question was "yes", does your pharmacy deliver the drug or device to a patient in this state by US mail, common carrier, or delivery services?	☐ YES	☐ NO

15 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