

TEXAS PHARMACY LICENSE APPLICATION

Institutional/Hospital/ASC Pharmacy (Class C) License

PLEASE READ CAREFULLY: Pharmacy applications status – allow 10 business days before contacting TSBP regarding the application status. Completed applications *may* take approximately 90 days for a license to be issued.

Failure to submit all required documentation will result in a delay of licensure. Questions regarding the application can be directed to the Pharmacy Licensing Specialist either by email to pharmacies@pharmacy.texas.gov or by phone at (512) 305-9127.

NOTICE: According to [Texas Occupations Code § 565.0551](#), the Executive Director of the Texas State Board of Pharmacy may require a license holder to submit a surety bond to the board.

- The Institutional/Hospital/Ambulatory Surgery Center (ASC) Class-C Information Form (LIC-Class_C) see form below.
- Check or Money Order for the Application Fee made payable to Texas State Board of Pharmacy. Fee calculation is provided in Box 1 on the Pharmacy Information Form.
- Ownership Information Form– See form below. TSBP requires the direct owner of the pharmacy to be listed. If you choose to also provide the parent company, you can submit separate ownership forms for each.
 - Copy of the entity’s Certificate of Formation as filed with the [Texas Secretary of State](#). This may also be called the Articles of Incorporation, Articles of Organization, or Application of Registration depending on the type of entity and when it was formed.
 - Additionally, if the entity is a Foreign Entity (i.e., the entity was formed in another state), provide a copy of the formation documents as filed in the jurisdiction of formation.
 - Verification of an ACTIVE [Franchise Tax Account Status](#) from the Texas Comptroller. Provide documentation from the Texas Comptroller that shows the entity has an ACTIVE Franchise Tax Account Status.
 - Organizational Chart: Provide an organizational chart that shows multi-levels of ownership and relation to the pharmacy.
- [Managing Officer Forms for each officer \(LIC-021\)](#) (attach a separate page if listing more than four officers).
*Per Texas Pharmacy [Rule 291.1](#) “Managing Officers are defined as the top four executive officers, including the corporate officer in charge of pharmacy operations, who are designated by the partnership or corporation to be jointly responsible for the legal operation of the pharmacy.”
 - Copy of Officers’ State Issue Photo ID. Acceptable Photo IDs are: Current Driver’s License, State Issued Identification Card or US Passport.
 - Verification of Officers’ Social Security Number – Submit a copy of the individual’s Social Security Card OR a copy of the individual’s W2, that shows the full SSN and Name of the individual, with all financial information redacted.
- Lease Agreement or Proof of Property Ownership (ex: property deed), including the pharmacy floor plan.
- Letter of Credit Worthiness - Submit a letter from the pharmacy’s primary drug distributor and/or wholesaler that verifies the pharmacy applicant’s credit worthiness. The letter must come from an entity that has an active license with [Texas Department of State Health Services \(DSHS\)](#) and be for the specific pharmacy and/or for the pharmacy owner.
- In accordance with [Texas Pharmacy Act, Section 560.052](#), the Texas State Board of Pharmacy cannot issue a license to a Class C Pharmacy until or unless it has been verified that the facility has substantially completed the requirements for licensure with the Texas Health and Human Services Commission (HHSC).

NOTE: TSBP may request additional documentation to confirm or substantiate information submitted on the application.

IMPORTANT: If applying for a Change of Ownership, refer to the [Change of Ownership Instructions](#) for the Change of Ownership Checklist and additional items required.



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FOR TSBP USE ONLY			
File #	App #	Entity #	Trans Code#
			1022
Amount Rcv'd	License #	AFL Date	

1	This application MUST be submitted with a check or money order made payable to the Texas State Board of Pharmacy. Use the column to the right to calculate the fee for the application.	Pharmacy Application Fee	\$ 516.00
		Number of Balances/Scales X \$25.00 ea	\$ _____
		Total DUE	\$ _____

NOTICE: According to [Texas Occupations Code §565.0551](#), the Executive Director of the Texas State Board of Pharmacy may require a license holder to submit a surety bond to the board.

Print or Type

2 Pharmacy (Facility) Information

Pharmacy Name: _____
Doing business as (dba) – Name listed on the prescription labels/signage

Pharmacy Address: _____
Street Address (Inspectable Location) Suite/Unit #

City _____ State _____ ZIP Code _____

Pharmacy Phone: _____ Pharmacy Email: _____
 Pharmacy Fax Number: _____ Web Address: _____
 Pharmacy Hours: Mon-Fri: _____ Sat: _____ Sun: _____

3 Type of Ownership

- Sole Proprietorship/Individual
 Corporation (Includes Non-Profit)
 Government
 Partnership
 Limited Liability Company
 Other (specify) _____

4 Type of Pharmacy

- Hospital Independent
 Ambulatory Surgery Center
 Hospital Multi/Chain (5 or More)
 Other (Specify): _____

5 Services Provided by Pharmacy (check all that apply)

- 24 Hour Service
 Compounding, Non-Sterile
 Pharmacist Admin. Immunizations
 503b Outsourcing Facility
 Compounding, Office Use
 Shipping Prescriptions Out-of-State
 Closed Door
 Home Delivery
 Veterinary Prescriptions
 Compounding Sterile, LOW Risk
 Infusion
 Rural Hospital
 Compounding Sterile, MED Risk
 Nuclear
 Tech Check Tech
 Compounding Sterile, HIGH Risk
 Outpatient Prescriptions
 Other (Specify): _____

6 Pharmacist-in-Charge Attestation

By my signature, I acknowledge that I am employed by the pharmacy listed above and that I am the Pharmacist-in-Charge of this pharmacy. I attest that I have read and understand the laws and rules relating to this class of pharmacy. **THIS SIGNATURE MUST BE NOTARIZED.**

Print or Type Name of Pharmacist in Charge _____ License # _____ Day Of _____, 20____

Signature of Pharmacist in Charge _____ Date _____ Notary Public _____

Subscribed and sworn to before me this



7 List of Staff Pharmacists and Pharmacy Technicians (Attach a list if additional room is needed)			
Name of Staff RPh or Technician	License/Registration #	Name of Staff RPh or Technician	License/Registration #

8 Answer the following questions regarding the Hospital or Ambulatory Surgical Center:

A) Is the facility an inpatient hospital maintained and operated by the State of Texas? (If Yes, SKIP 8C) Yes No

B) Will the pharmacy be operated by hospital/pharmacy management company? Yes No
 If yes, provide the Name of the Management Company and attach a copy of the Service Agreement
 Name of Management Company: _____

C) Is the facility already licensed with the Texas Health and Human Services Commission (HHSC?) * Yes No
 If yes, indicate the license type and provide the license number as issued by HHSC. License Number: _____
 Hospital - Number of Beds: _____ Hospice Inpatient Ambulatory Surgical Center Other: _____
 If no, has the facility already submitted an application with HHSC? Yes No

9 The Owner or One of the Managing Officers MUST Answer the Following Questions:

a. 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? (e.g., surrender, revocation, reinstatement, suspension, fine, probation, restriction.) Include such information for **all** states, including Texas, and for all regulated professions. Yes No

b. 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
If you answered "YES" to Question 1 and/or Question 2, 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 conditions and/or probation:

c. Are the customer service areas of the pharmacy accessible to disabled persons, as defined by federal law? Yes No

d. 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
 Spanish American Sign Language
 Vietnamese AT&T Translating Service
 Telecommunication Device for the Deaf (TDD) Other: _____

e. Does this Pharmacy participate in the Texas Medicaid Program? Yes No

Owner/Managing Officer Attestation

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 and Rules. 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 before me this _____ Day Of _____, 20 _____

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



TEXAS PHARMACY LICENSE APPLICATION Ownership Information Form

1 Pharmacy (Facility) Information	
a.	Pharmacy Name: _____ <i>Doing business as (dba) – Name listed on the prescription labels/signage</i>
b.	Pharmacy Address: _____ <i>Street Address (Inspectable Location) Suite/Unit #</i>
	_____ <i>City</i> <i>State</i> <i>Zip Code</i>
2 Designated Person of Contact for Pharmacy Person Authorized by Owner/Officer to Discuss Application Material with TSBP Staff	
Full Name: _____	Title: _____
Contact Phone: _____	Contact Email: _____
3 OWNERSHIP INFORMATION The below information should match all Secretary of State, Comptroller, and IRS Filings.	
a. Entity's Federal Employer ID Number (FEIN)	b. Type of Ownership <input type="checkbox"/> Sole Proprietorship/Individual <input type="checkbox"/> Corporation (Includes Non-Profit) <input type="checkbox"/> Partnership <input type="checkbox"/> Government <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Other (specify) _____
c. Direct Owner of Pharmacy (i.e., Corp, Inc, LLC, LP, PA, LTD, etc.)	
d. Corporate Mailing Address for Owner	
_____ <i>Street Address</i> <i>Suite/Unit #</i>	
_____ <i>City</i> <i>State</i> <i>Zip/Postal Code</i>	

ATTEST: I hereby attest that the foregoing statements 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

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

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

Notary Public



Once your application is determined complete, an email will be submitted to the designated person of contact for the pharmacy. TSBP will verify background information for each officer/owner provided.

THE **FOLLOWING MUST BE SUBMITTED WITH THIS APPLICATION:**

- [Managing Officer Form\(s\) \(LIC-021\)](#) for each Officer
- Lease Agreement or Property Deed, including the pharmacy floor plan
- Articles of Incorporation/Organization
- Organization Chart
- Proof of Credit Worthiness from your Primary Wholesaler