NON-RESIDENT PHARMACY PERMIT APPLICATION INSTRUCTIONS

- Complete the attached Maryland Board of Pharmacy's **Application for Non-Resident Pharmacy Permit**. The box for the relevant application type (New, New Ownership, New Location, Renewal, Late Renewal, or Reinstatement) must be selected.

> **NOTE:** A Non-Resident Pharmacy is a pharmacy located outside this State that, in the normal course of business, as determined by the Board, ships, mails, or delivers drugs or devices to a person in this State pursuant to prescriptions. A Non-Resident Pharmacy shall be operated in compliance with the laws and regulations of the state in which it is located; and shall be in compliance with the laws and regulations of the Board. For further details, please review MD Code Ann., Heath Occ.§12-404.

- Submit the completed application with all attachments and a check made payable to the Maryland Board of Pharmacy in the appropriate amount to:

Maryland Board of Pharmacy, PO BOX 2024, Baltimore, MD 21203-2024.

- Applications sent overnight or through priority mail must be addressed to the appropriate lockbox and sent to:

Wells Fargo Bank, Attn: State of MD – Board of Pharmacy, Lockbox 2024
2005 Market Street 5th Floor
Philadelphia, PA 19103-7042

- The application process must be completed within one year from submission of the initial application. Applicants failing to complete the process within one year will be required to submit a new application and fee. Fees paid for applications that have expired will not be refunded or credited.
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- A Non-Resident Pharmacy application must include the name and licensure information for the pharmacist who is licensed by the Maryland Board of Pharmacy and is designated as “the pharmacist responsible for providing pharmaceutical services to patients in” Maryland, Md. Code Ann., Health Occ. § 12-403(d), and whom all Maryland patients who call with inquiries will be referred, -, Md. Code Ann., Health Occ. § 12-403(f)(6).

- A completed application must include:

    - A copy of the most recent inspection report and the name of the agency that performed the inspection;
    - A list of all federal and state licenses, registrations, and/or permits;
    - A list of all disciplinary actions taken by federal and/or state agencies against the pharmacy and/or any principals, owners, directors, or officers;
    - The name and Maryland pharmacist license number for the pharmacist responsible for providing pharmaceutical services to patients in Maryland (if applicable);
    - The appropriate application fee ($700 for New, New Ownership and New Location, $500 for Renewal, $700 for late Renewal, and $1,050 for Reinstatement applications); and
    - Any other documentation required in Md Code Ann., Health Occ HO 12-404.
- If the actual date of the pharmacy opening is different from the Proposed Date of Opening or Ownership/Location Change on the application, please contact the Board as soon as possible and provide the new date.

- All Maryland businesses must pay all delinquent Maryland Use and Sales taxes before their

permit can be renewed. All permits expire May 31st of each even-numbered year. To settle a past business tax liability, call 410-649-0633 in Central Maryland or toll-free at 1-888-614-6337.

- Before returning your completed application to the Board of Pharmacy, it is recommended that you maintain a copy of your submission and attachments for your records.

- When there is a name change of the pharmacy or a change in the pharmacist who is licensed by the state of Maryland as per the requirement for a Non-Resident Pharmacy Permit, a fee or inspection is not required. However, legal documentation of the name change or pharmacist change must be submitted. Please contact the Board for more information.

NOTE: The Board must be notified of any change in the pharmacy name, ownership, location, or Maryland licensed pharmacist within thirty (30) days of the change if the change occurs before the annual renewal.

NOTE: Please allow four to six weeks for the Board to process your completed application.

NOTE: The application fee is a non-refundable, administrative fee.

Maryland Board of Pharmacy
4201 Patterson Avenue
Baltimore MD 21215-2299
Phone: 410-764-4755
Fax: 410-358-6207
www.dhmh.maryland.gov/pharmacy

APPLICATION FOR NON-RESIDENT PHARMACY PERMIT

- Please print clearly in ink or type in upper case letters only.
- Complete all application sections and sign. If a question is not applicable, an explanation must be provided. Incomplete forms will delay the issuance of your permit.

APPLICATION TYPE					
☐ **New Application** **Fee: $700.00**	☐ **New Ownership** **Fee: $700.00**	☐ **New Location** **Fee: $700.00**	☐ **Renewal** **Fee: $500.00**	☐ **Late Renewal** **Fee: $700.00**	☐ **Reinstatement** **Fee: $1,050.00**

1. APPLICANT INFORMATION	
A. Name of Applicant: ***(name in which company is doing business)***	
Maryland Permit Number *(if applicable)*:	

B. Facility Address *(physical location of establishment which should be reflected on all sales invoices and shipping documents)*:					
Street Address:				**Suite #:**	
City:		**State:**		**Zip Code:**	
Telephone #:				**Fax #:**	
Web Site:			**Email Address:**		
Federal Tax ID #:					

C. Date of Proposed Opening or Ownership / Location Change	

D. Type of Business (check all that apply):		
☐Sole Proprietorship	☐Partnership	☐C Corporation
☐S Corporation	☐LLC	☐Other (please explain): _____
E. Date Business was Established:		

F. Is this the first application that you have submitted for this facility?	☐YES ☐NO
If not, provide the date of the most recent submission:	

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G.	If this application is being submitted for an ownership change, provide the name of the previous owner and current permit number for the facility	
	Name:	
	Permit #:	

2. FACILITY INFORMATION		
A.	Date of last inspection by a state agency, accreditation program, or FDA: *(attach most recent inspection report, which should be within the last 2 years)If company is doing sterile compounding a "*sterile inspection report required."	
	If your State does not require inspections, check here:	

B.	DEA Registration #:		Expiration Date:	
	Maryland CDS Registration # *(attach copies of registration certificates)*		Expiration Date:	

C.	State and Federal permit/license/registration numbers *(Include a copy of the permit/license/registration) (attach additional pages if necessary)*:	
	LICENSING BODY	PERMIT / LICENSE / REGISTRATION NUMBER

D.	Does this Corporation, Partnership or Individual have a subsidiary or other affiliate located in Maryland?	☐YES ☐NO
	If YES, provide the company name and address:	

3. OPERATIONS				
A.	Hours of Operation			
	Sunday		Thursday	
	Monday		Friday	
	Tuesday		Saturday	
	Wednesday			

B.	CHECK ALL APPLICABLE DESCRIPTIONS OF THE PHARMACY:		
	☐ Community (less than 10 stores)	☐ Chain (10 or more stores)	☐ Clinic
	☐ Consultant	☐ Correctional Institution	☐ Free Clinic
	☐ Durable Medical Equipment (DME) / Device	☐ HMO	☐ Home Health
	☐ Hospital	☐ Independent	☐ Internet
	☐ Intravenous Therapy	☐ Comprehensive Care (Long Term Care)	☐ Mail Order
	☐ Managed Care	☐ Nuclear	☐ Nursing Home
	☐ Pharmacy Service Center	☐ Research	
	☐ Veterinary	☐ Assisted Living Facility	☐ Non-Sterile Compounding
	☐ Sterile Compounding: "sterile inspection report required."		
	☐ Other (please describe):_____		
	☐ Specialty (please describe):_____		

C.	Does this Pharmacy conduct business on the Internet?	☐ YES ☐ NO
	If YES, what services?	
	Is your business address and telephone number specified on your website(s)?	☐ YES ☐ NO

D.	What other business website name(s) does this establishment use, other than that listed in the applicant information section or the previous question?

E.	Identify the entities and method for shipping prescription drugs in to Maryland:			
	Name	Telephone	Method	MD Permit #

F.	During its regular hours of operation, but not less than 6 days a week and for a minimum of 40 hours per week, non-resident pharmacies must provide a toll-free telephone service to facilitate communication between patients in this State and pharmacist who has access to the patient's prescription records.	
	List the Pharmacy Toll-Free Telephone Number(s):	

G.	Is the toll-free telephone number on the prescription label?	☐ YES ☐ NO

4. OWNERSHIP

Please include the following on a separate sheet:

1. **Full name, title, date of birth, and business address for owner, sole proprietor, each partner, and/or each corporate director or officer;**
2. **Full name, title, date of birth, and business address for each manager of an LLC;**
3. **Full name, title, date of birth and business address for each shareholder owning 10% or more of the shares for a *non-publicly traded corporation*; and**
4. **Corporate name for a non-publicly traded corporation.**
5. **Are any of the owners licensed in any other healthcare profession?** ☐YES ☐NO

If yes, provide the names of these owners along with their corresponding licensed profession, state license number, and expiration date.

6. Do you currently or have you ever owned, in whole or in part, another pharmacy or distributor entity? If so, please list establishment name, location, and permit number.

_____

NAME OF THE OWNER	TYPE OF HEALTHCARE PROFESSION	STATE LICENSE #	EXP. DATE

5. DISCIPLINARY ACTIONS

Please include a separate sheet listing all disciplinary actions by federal or state agencies against the pharmacy, as well as any such actions against principals, owners, directors, officers, or employees. Please include documentation of any corrective actions taken in response to any disciplinary actions and any final orders issued by any federal or state agencies. **Renewal, relocation, and reinstatement applicants - please only include information since the last application you submitted to the Board.**

Attachment included: ☐YES ☐NO

6. PERSONNEL

A. Complete pharmacist, pharmacy interns, and pharmacy technician employees' name(s), employment status, license/registration number and expiration date. Attach additional sheets if necessary

EMPLOYEE NAME	FULL / PART-TIME	RESIDENT STATE LICENSE / REGISTRATION #	EXPIRATION DATE
	☐ F/T ☐ P/T		
	☐ F/T ☐ P/T		
	☐ F/T ☐ P/T		
	☐ F/T ☐ P/T		
	☐ F/T ☐ P/T		
	☐ F/T ☐ P/T		

B. Complete the information for the pharmacist at this establishment who is licensed in the state of Maryland:			
NAME	**EMPLOYMENT STATUS FULL / PART-TIME**	**MARYLAND PHARMACIST LICENSE #:**	**MARYLAND PHARMACIST LICENSE EXPIRATION DATE**
	☐ F/T ☐ P/T		

If the pharmacist is not yet licensed in Maryland, date the pharmacist application was submitted to the Maryland Board of Pharmacy:	

I confirm that the Maryland licensed pharmacist will regularly be available on site as needed to meet the needs of Maryland patients. _____ Yes _____ No

C. Agent located in Maryland officially designated to accept Service of Process:					
An agent is any person you designate to accept legal documents from the Board of Pharmacy on your behalf. When legal documents are received by your designated agent, the documents are considered by law to have been received by you. Thus, you should choose an individual you can trust to forward correspondence to you in a timely fashion. For this reason, many people choose an attorney, an accountant, or other professional who owes them a fiduciary duty. You may designate any person you choose; <u>however, your agent must be a resident of Maryland. List your agent information below and provide proof of the agent agreement.</u>					
Name:					
Street Address:					
City:		**State:**		**Zip Code:**	

7. MARYLAND LAWS & REGULATIONS ATTESTATION
In order to operate as a Maryland Non-Resident pharmacy, the pharmacy must comply with certain provisions of Maryland law-specifically Md. Code Ann., Health Occ. § 12-403(b)(2), (7)-(12), and (19)-when dispensing prescription drugs or devices to patients in Maryland or "[o]therwise engaging in the practice of pharmacy" in Maryland. Md. Code Ann., Health Occ. § 12-403(f)(1).
By signing this application, I solemnly affirm under the penalties of perjury that the contents of this application are true to the best of my knowledge, information, and belief. I further certify that I am aware of and will meet the requirements of the Maryland Pharmacy Act and Maryland Board of Pharmacy regulations pertaining to Non-Resident Pharmacy Permitting. I understand that a Maryland Non-Resident Pharmacy Permit may be revoked if any statement made in this application is found to be false.

Signature of Legal Applicant:	

Business Telephone #:		Business Fax #:	
Name and Title:		Email Address:	
Corporation Name:		Date:	

8. LIST OF DESIGNEES		
If applicable, list the names of person and/or entity that you authorize the Board to release information about your application:		
Name of Organization	**Name of Person**	**Title**

9. ATTESTATION FOR REINSTATEMENT APPLICANTS ONLY
I hereby swear and affirm under penalty of perjury that _____ [*insert pharmacy or DME/Device only provider name*], permit no. _____, has not operated as a pharmacy or DME/Device only provider in the State of Maryland since the expiration of our most recent pharmacy permit, which expired on _____. I understand that a violation of Md. Code. Ann., Health Occ. Sec. 12-703, or its corresponding regulations may result in the imposition of a fine not to exceed $50,000.

Signature of Permit Holder:	_____

Printed Name of Permit Holder:		**Date:**	

10. APPLICATION CHECKLIST		
Application Fee ($500, $700, or $1,050)	☐YES	☐NO
Most Recent Inspection Report	☐YES	☐NO
Copies of DEA & Maryland CDS Registration Certificates	☐YES	☐NO
Copy of Permit(s) from State of Residence	☐YES	☐NO
Ownership Information	☐YES	☐NO
Maryland Resident Agent Information	☐YES	☐NO