PRESCRIPTION DRUG REPOSITORY PROGRAM APPLICATION
(HG 15-601 - 609)
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The Maryland Prescription Drug Repository Program (the "Program") was established to allow Maryland Board of Pharmacy (the "Board")- approved repositories to accept donated prescription drugs and medical supplies for the purpose of disposal (or, in limited circumstances with specific approval, dispensing the donated drugs to needy individuals).

An Application Must Be Filed:

- To become a repository that accepts donated prescription drugs or medical supplies for disposal (CDS* or Non-CDS);
- To become a repository that accepts donated prescription drugs or medical supplies for re-dispensing to needy individuals; or
- To notify the Board of a change in location or ownership of a pharmacy previously approved to be a repository under the Program.

***Please note –** a repository that accepts CDS for disposal must comply with the requirements of the Secure and Responsible Drug Disposal Act of 2010. *See* COMAR 10.34.33.07.

Eligible Applicants:

The Board will approve an applicant that:

- Is a Maryland licensed pharmacy in good standing with the Board;
- Does not have a final disciplinary order issued against it by the Board;
- Is not owned or operated by a permit holder who has not fulfilled the requirements of a final disciplinary order that may have been issued against the owner or operator by a health occupations board; and
- Assigns a pharmacist the responsibility to accept donated prescription drugs or medical supplies (if the repository *only* accepts non-CDS drugs and medical supplies).

PRESCRIPTION DRUG REPOSITORY APPLICATION INSTRUCTIONS

Please review all Program requirements under Health General §15-601 – 609, Annotated Code of Maryland and the related regulations at COMAR 10.34.33 before completing the Prescription Drug Repository Application. All questions must be thoroughly answered. A response or explanation must be provided for all questions. An approval may be delayed if appropriate responses to all questions are not provided.

Submit the completed application with all attachments and a check made payable to the Maryland Board of Pharmacy in the appropriate amount to:
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Maryland Board of Pharmacy, P.O. Box 2024, Baltimore, MD 21203-2024

I. Applicant Information

A. Application Type – Please indicate the services the applicant is seeking to provide in the state. Select one option only.
B. Please provide all requested information about the pharmacy where the service will be provided.
C. The legal applicant is the individual that is authorized to respond to questions and make any decision regarding the operation of the pharmacy. This individual may or may not be the same person that completes the application.

II. Ownership Description - Attach a list of the owners and corporate officers, for all levels of ownership. Include the following on the attachment: Name, Title, Percent ownership, Business address, Telephone Number, and Fax Number.

A. Indicate the date that the pharmacy/facility initially opened.
B. Indicate the date of the most recent inspection by the Board, Office of Controlled Substance Administration (OCSA), Office of Health Care Quality, and/or other health care facility licensing body in Maryland.
C. Attach a detailed explanation about any violations (federal, state or local convictions) as requested.
D. Indicate the type of ownership (select only one). If a corporation, list principal owners, indicate the corporate name, charter state and date of charter, and indicate whether it is a Public or Non-Public corporation.

III. Attestation – Each item must be read and initialed by the legal applicant.

IV. Legal Signature– The statement must be read and signed by the legal applicant.

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 PRESCRIPTION DRUG REPOSITORY (HG 15-601 - 609)

Please refer to instruction for completing the Application. Approval may be delayed if appropriate responses to all questions are not provided.

I. APPLICANT INFORMATION	
Date:	

A. APPLICATION TYPE: CHECK ALL THAT APPLY
____ **Disposal of Non-CDS and Medical Supplies ONLY**
____ **Disposal of CDS, Non-CDS, and Medical Supplies**
____ **Re-dispensing of Donated Prescription Drugs and Medical Supplies to Needy Individuals**

B. APPLICANT FACILITY INFORMATION					
Pharmacy Name (Corporate Name)–					
Doing Business As (DBA) or Trade Name:					
Current Permit/License Number					
Street Address:					
City:		**State:**		**Zip:**	
Business Telephone #:					
Business Fax #:					
Web Site Address:					
Email Address:					
Federal Tax ID #:					
DEA Retail Drug Collector # (if "yes" provide a copy):	☐ **Yes (_____) Number** ☐ **N/A**				
Please list any additional DEA receptacles located outside the pharmacy. (ONLY applicable to applicants that accept CDS for disposal)					

C. PHARMACY CONTACT INFORMATION			
Legal Representative			
Name:		Title:	
Telephone:		Fax:	

Person Completing Application			
Name:		Title:	
Telephone:		Fax:	

II. OWNERSHIP INFORMATION	
A. Date Established:	

B. Date of Last State Inspection:	_____Maryland Board of Pharmacy _____OCSA

C. Has the corporation or any officers thereof, or any partners, or the individual owner ever been convicted of violations of any federal, State, or local laws or regulations dealing with drug products or alcohol?	☐YES ☐ NO (If yes, attach a detailed explanation)

D. OWNERSHIP INFORMATION IS ATTACHED:			☐YES ☐ NO
	Individual Ownership Partnership Corporation		
Corporate Name:			
Principal Owner(s):			
Charter State:		Date:	
	☐Non-Public ☐Public		

III. ATTESTATION	
Please initial each statement:	
____	a. I hereby certify that the pharmacy is equipped with sanitary appliances such as toilets, plumbing, running water, lighting, etc. in order to maintain the premises in a clean and orderly manner.
____	b. I hereby certify that the pharmacy meets the requirements of the attached Code of Maryland Regulations regarding the Prescription Drug Repository Program (10.34.33).
____	c. I hereby certify that the pharmacy does not have a final disciplinary order issued against it by a health occupations board.

____	**d. I hereby certify that the owner or operator of the pharmacy has fulfilled any requirements of a final disciplinary order that may have been issued against the owner or operator by a health occupations board.**

IV. LEGAL SIGNATURE	
I understand that obtaining approval to be a repository by making false representations may result in the revocation of approval to operate a repository in Maryland. 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.	
Signature of Legal Applicant:	
Name and Title:	
Business Telephone #:	
Business Fax #:	
Email Address:	
Date:	