**MARYLAND PHARMACY PERMIT APPLICATION**

**INSTRUCTIONS**

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

**NOTE:** A Pharmacy is an establishment in which prescription or nonprescription drugs or devices are dispensed to patients. A person shall hold a Pharmacy Permit issued by the Maryland Board of Pharmacy before the person may establish or operate a pharmacy in the State of Maryland. Refer to Health Occupations, §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, 4201 Patterson Avenue, Baltimore, MD 21215.
  + An application fee of **$ 700.00** is required for a New Pharmacy permit or changes to the Pharmacy permit.
  + An application fee of **$ 600.00** is required for a Pharmacy Permit Renewal.
  + An application fee of **$ 800.00** ($600 renewal fee + $200 late fee) shall be paid to the Board if a renewal application is post-marked between May 2nd and May 31st.
  + An application fee of **$ 1,150.00** ($600 renewal fee + $550 reinstatement fee) shall be paid to the Board if a renewal application is post-marked after May 31st.
* 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.
* Please be advised that effective July 1, 2012, the expiration date for pharmacy permits with the Maryland Board of Pharmacy (the “Board”) changed from December 31 to May 31. Pharmacy permit renewals will occur in even-numbered years. *See* Md. Code Ann., Health Occ. § 12-6C-06(a) (2012 Supplement).

**NOTE:** Institutional Pharmacies: under 10.34.03, any pharmacy under your ownership that does not satisfy the definition/requirements of a “decentralized pharmacy” must file a separate pharmacy application and pay a separate application fee. A decentralized pharmacy is defined as an institutional pharmacy which provides services for the population of an institutional facility and is dependent on another institutional pharmacy for (1) administrative control, (2) staffing with a licensed pharmacist physically available on site in the decentralized pharmacy to supervise the performance of delegated pharmacy acts and (3) drug procurement. A decentralized pharmacy location is also located in the same building or pavilion (detached or semidetached part of a hospital devoted to a special use) as the dependant institutional pharmacy. All decentralized pharmacy locations and personnel must be listed on the initial or the renewal pharmacy application. Attachment 1 should be completed for each decentralized pharmacy that is affiliated with the applicant.

If an Institutional Pharmacy institutes a decentralized pharmacy in between renewal periods, they must inform the board of pharmacy of that decentralized pharmacy utilizing Attachment 1 and a floor plan of the decentralized pharmacy within 30 days of the opening of the decentralized pharmacy.

* A completed application must include:
  + Copies of all federal and state licenses, registrations, and/or permits;
  + Floor plan diagram of the pharmacy and all decentralized pharmacies;
  + A list of all disciplinary actions taken by federal and/or state agencies against the pharmacy, pharmacy employees or any principals, owners, directors, or officers;
  + The appropriate application fee ($700 for New, New Ownership and New Location, $600 for Renewal, $800 for late Renewal, and $1,150 for Reinstatement applications); and
  + Any other documentation required in HO §12–404.
* For renewing applicants **(MARYLAND ONLY)**:
  + **DO NOT attach the following requested attachments when submitting your application:**
    - Most recent Maryland Board inspection
    - Pharmacy floor plan
    - Copy of pharmacist license(s)
    - Copy of pharmacy technician license(s).
  + **Please attach a list of names and permit numbers for all currently employed pharmacists and pharmacy technicians.**
  + **ALL OTHER REQUESTED ATTACHMENTS MUST BE ATTACHED**
* An inspection of the premises located in Maryland must be arranged two weeks prior to opening.
* If the actual date 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 Maryland Unemployment and Use & Sales taxes before their permit can be renewed. 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.
* Applicants located outside of Maryland must complete the Application for Non-Resident Pharmacy Permit.
* Pharmacies whose practice is specific to a specialty/specialties should complete the Application for Pharmacy Waiver Permit. A Waiver Pharmacy must limit practice only to the specialty specified on the waiver application. This means the pharmacy cannot perform pharmaceutical services other than those allowed by the restrictive waiver.

**NOTE:** The board must be notified of any change in the pharmacy name, ownership, location, or decentralized pharmacy 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.

Application Revision: 11/2013

**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 MARYLAND PHARMACY PERMIT

***BOARD USE ONLY***

Permit Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approval Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Approval By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: $600.00** | **Late Renewal**  **Fee: $800.00** | **Reinstatement**  **Fee: $1,150.00** |

**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 No.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number Fax Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Website Email Address Federal Tax Id No.

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)*

If the Pharmacy is a Corporation, check the appropriate box:  Non-Public  Public

E. Date Business was established: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

F. If this application is being submitted for an ownership change, provide the name of the previous owner:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. FACILITY INFORMATION**

A. Date of last inspection by a state agency, accreditation program, or FDA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(attach most recent inspection report)*

B. DEA Registration # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maryland CDS Registration # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(attach copies of registration certificates)*

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**3. OPERATIONS**

A. Hours of operation:

Sunday \_\_\_\_\_\_\_\_\_ Thursday \_\_\_\_\_\_\_\_\_\_

Monday \_\_\_\_\_\_\_\_\_ Friday \_\_\_\_\_\_\_\_\_\_

Tuesday \_\_\_\_\_\_\_\_\_ Saturday \_\_\_\_\_\_\_\_\_\_

Wednesday \_\_\_\_\_\_\_\_\_

B. CHECK ALL APPLICABLE DESCRIPTIONS OF THE PHARMACY:

Assisted Living  Chain (10 or more stores)  Clinic

Community (less than 10 stores)  Comprehensive Care  Consultant

Correctional Institution  Free Clinic  HMO

Durable Medical Equipment (DME)/Device  Home Health  Hospital

Independent  Internet  Intravenous

Therapy

Long Term Care  Mail Order  Managed Care

Non Sterile Compounding  Nuclear  Nursing Home

Pharmacy Service Center  Research  Sterile

Compounding

Veterinary

Other, 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?

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E. What reference materials are kept in the pharmacy reference library?

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**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.

A. Does your total annual dollar volume of prescription drugs sold or repacked to licensed practitioners and other establishments exceed five percent of your total prescription drug sales?  **YES  NO**

If yes, provide Maryland Distributer permit number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B. Do you currently or have you ever owned a pharmacy or distributor in Maryland?  **YES  NO**

If yes, provide establishment name and permit number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 your last application with the Board.**

**6. PERSONNEL**

A. The Workman's Compensation Law (Art. 101 Sec. 1-102) requires that you carry workman's compensation insurance for two or more employee, including the permit holder.

Workman Compensation Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B. The number of staff employed at this location:

1. Number of Pharmacists \_\_\_\_\_\_ Number of Pharmacist Vacancies

1. Number of Pharmacy Technicians \_\_\_\_\_\_ Number of Pharmacy Technician Vacancies
2. Number of Unlicensed/Unregistered Personnel in the Pharmacy

Number of Unlicensed/Unregistered Personnel in the Pharmacy Vacancies

C. Complete pharmacist and pharmacy technician employees name(s), employment status, license/registration number and expiration date.Employee State Expiration Name Full-time/Part-Time License/Registration # Date

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**The Board must be notified in 30 days of any changes in pharmacist/pharmacy technician employment**

Attach additional sheets if necessary

D. Describe the current method of verifying the expiration dates of licensure/registration for pharmacy employees:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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E. Provide the name and contact information for the person responsible for verifying employee licensure/registration information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Title Telephone Email

F. Institutional Pharmacies with Decentralized Pharmacy(ies)

Total number of decentralized pharmacy locations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name(s) and permit number of each decentralized pharmacy location:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Attachment 1 should be completed for each decentralized pharmacy location affiliated with this application.

**7. MARYLAND LAWS & REGULATIONS ATTESTATION**

In order to operate as a Maryland pharmacy, the permit holder must 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. In addition, the pharmacy must meet the requirements of the Code of Maryland Regulations regarding pharmacy equipment (10.34.07).

I certify that the Maryland Pharmacy Applicant will comply with all Maryland laws and regulations pertaining to a Maryland Pharmacy Permit.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Legal Applicant Business Telephone Number Business Fax Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type Name and Title Email Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Corporation Name

**8. ATTESTATION FOR REINSTATEMENT APPLICANTS ONLY**

I hereby swear and affirm under penalty of perjury that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [insert pharmacy], permit no. \_\_\_\_\_\_\_\_\_\_\_\_\_\_, has not operated as a pharmacy 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. 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 Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Printed name of the Permit Holder

**9. SIGNATURE**

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 Maryland Pharmacy Permitting. I understand that a Maryland Pharmacy Permit may be revoked if any assertion made in this application is found to be false.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Applicant Business Telephone Number Business Fax Number

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**10. APPLICATION CHECKLIST**

Application Fee ($600, $700, $800, or $1,150)  **YES  NO**

Most Recent Inspection Report (If applicable)  **YES  NO**

Copies of DEA & Maryland CDS Registration Certificates  **YES  NO**

Copy of Permit(s) from State of Residence   **YES  NO**

Floor plan diagram of the pharmacy (size 8 ½ x 11)  **YES  NO**

Floor plan diagram for each decentralized pharmacy  **YES  NO**

affiliated with this application (if applicable)

Ownership Information  **YES  NO**

**APPLICATION FOR MARYLAND PHARMACY PERMIT**

**ATTACHMENT 1**

**DECENTRALIZED PHARMACY INFORMATION**

**An attachment must be completed for each decentralized pharmacy affiliated with this application**

Name of Decentralized Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Actual Physical Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hours of operation:

Sunday \_\_\_\_\_\_\_\_\_ Thursday \_\_\_\_\_\_\_\_\_\_

Monday \_\_\_\_\_\_\_\_\_ Friday \_\_\_\_\_\_\_\_\_\_

Tuesday \_\_\_\_\_\_\_\_\_ Saturday \_\_\_\_\_\_\_\_\_\_

Wednesday \_\_\_\_\_\_\_\_\_

A. The number of staff employed in this decentralized pharmacy:

1. # Pharmacists \_\_\_\_\_\_ # Pharmacist Vacancies

1. # Pharmacy Technicians \_\_\_\_\_\_ # Pharmacy Technician Vacancies
2. # Unlicensed/Unregistered Personnel in the Pharmacy

# Unlicensed/Unregistered Personnel in the Pharmacy Vacancies \_\_\_\_\_\_\_\_\_

C. Complete pharmacist and pharmacy technician employees name(s), employment status, license/registration number and expiration date.

Employee State Expiration

Name Full-time/Part-Time License/Registration # Date

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Attach additional sheets if necessary

C. Describe the current method of verifying the expiration dates of licensure/registration for pharmacy employees at this decentralized pharmacy:

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D. Provide the name and contact information for the person responsible for verifying employee licensure/registration information for this decentralized pharmacy:

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Name Title Telephone Email