



**OKLAHOMA STATE BOARD OF PHARMACY**

4545 Lincoln Blvd, Ste 112, Oklahoma City, OK 73105-3488  
 Phone: (405) 521-3815 / Fax: (405) 521-3758  
[www.pharmacy.ok.gov](http://www.pharmacy.ok.gov) / e-mail: [pharmacy@pharmacy.ok.gov](mailto:pharmacy@pharmacy.ok.gov)

**FEES** [✓ all that apply]

Pharmacy License -  \$ \_\_\_\_\_ (see fee below)  
 Drug Supplier Permit -  \$ 20.00 (in-state only)  
 Parenteral Permit -  \$ 75.00 (in-state only)  
**TOTAL AMOUNT DUE** \$ \_\_\_\_\_

**2008-2009 NOTICE OF RENEWAL OF PHARMACY LICENSE**

**A.** License No. \_\_\_\_\_

Please PRINT clearly – list name and/or dba and address

**Fee doubles 15 days after expiration**  
**EXPIRES:** \_\_\_\_\_

<b>B. Type of Ownership</b> (✓ one)	INDIVIDUAL
	PARTNERSHIP
	CORPORATION
	LLC
	GOVERNMENT

<b>C. CHANGE OF OWNER SINCE PREVIOUS RENEWAL?</b>	<b>YES</b>	<b>NO</b>	A. For a Change of Ownership less than 20% - complete & return "Notice of Renewal" application
			B. For a Change of Ownership 20% or greater - complete & return an "Application for Pharmacy License" along with corresponding ownership information form ( <a href="http://www.pharmacy.ok.gov">see www.pharmacy.ok.gov</a> )

<b>D. Type of Pharmacy</b> (✓ one)	CHARITABLE - \$75			
	HOSPITAL - \$150		# BEDS _____	
	HOSPITAL DRUG ROOM - \$40		# BEDS _____	
	NON-RESIDENT (Out-of-State) - \$150		★ <b>Must Attach a Copy of Resident State Pharmacy License</b>	
	RETAIL (✓ type) - \$150		Independent	Chain
		Closed Door	Nuclear	Other _____

**ALL RESIDENT (IN-STATE) PHARMACIES MUST ATTACH A COPY OF THEIR ANNUAL CDS INVENTORY TAKEN BETWEEN MAY 1ST - JULY 1ST**

**E.** Located in \_\_\_\_\_ county. e-mail: \_\_\_\_\_  
 Phone: ( ) \_\_\_\_\_ ★ Toll Free: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_  
 Pharmacy hours: Mon-Fri \_\_\_\_\_ Sat \_\_\_\_\_ Sun \_\_\_\_\_ [★required for non-resident]

**F. 1.** The following licensed pharmacist is designated as **Pharmacist-In-Charge** of the above pharmacy.  
*By my signature, I acknowledge that I am employed by the pharmacy named above and that I am the pharmacist-in-charge. My business practices will conform to the Rules of Professional Conduct and the pharmacy laws and rules of the State of Oklahoma.*

**Printed Name:** \_\_\_\_\_ **Cert. No.** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**2.** The following person is designated as **Drug Room Supervisor** of the above hospital drug room.  
**Printed Name & Title:** \_\_\_\_\_ (DPh, RN or LPN)

**G.** Licensed **Pharmacists and Technicians** employed by this pharmacy (*use additional sheet if necessary*):

Cert. #	Pharmacists (Print Name)	Full Time/	Part Time/	Permit #	Technicians (Print Name)	Full Time/	Part Time/

## H. APPLICANT HISTORY

Please answer each of the following questions by putting a check (✓) in the appropriate box on the right. For the purposes of the questions below, "applicant" means the person signing the application, owner of the pharmacy and the pharmacy.

1.	Is there any disciplinary action pending against the applicant by any licensing jurisdiction, the FDA, DEA, or any state drug enforcement authority?	Yes [ ]	No [ ]
2.	Since the last renewal or within the last 15 months, has the applicant(s), or if the applicant is a business entity, any of the business entity's owners, officers, directors, members, partners or stockholders ever been charged and/or convicted of any drug related crime or any felony? <i>(If the applicant is a business entity, you need not include members, partners or stockholders in this question unless they currently serve as managers, officers or directors of the applicant business, or own more than twenty percent (20%) of the business entity.)</i>	Yes [ ]	No [ ]
3.	Are there any criminal charges pending against the applicant(s), or if the applicant is a business entity, any of the business entity's owners, officers, directors, members, partners or stockholders involving the practice of pharmacy? <i>(If the applicant is a business entity, you need not include members, partners or stockholders in this question unless they currently serve as managers, officers or directors of the applicant business, or own more than twenty percent (20%) of the business entity.)</i>	Yes [ ]	No [ ]
4.	Since the last renewal or within the last 15 months, has any sanction or disciplinary action been taken regarding any license permit or registration issued to the applicant, officers, directors, partners or stockholders involving the practice of pharmacy? <i>(If the applicant is a business entity, you need not include members, partners or stockholders in this question unless they currently serve as managers, officers or directors of the applicant business, or own more than twenty percent (20%) of the business entity.)</i>	Yes [ ]	No [ ]
5.	Since the last renewal or within the last 15 months, has the applicant had any application for a license or permit refused or denied by any licensing authority?	Yes [ ]	No [ ]
6.	Since the last renewal or within the last 15 months, has the applicant had a registration issued by a controlled substance authority revoked, suspended, surrendered, limited, or restricted?	Yes [ ]	No [ ]

All "YES" answers MUST be explained in detail in a separate SIGNED and NOTARIZED affidavit. The affidavit should include all relevant dates, and identify the relevant jurisdiction and/or entity involved. Failure to disclose any of the requested information may result in the denial of your application or other appropriate action.

**I. RESPONSIBLE PERSON:** List Name & Address of person responsible for accepting service for applicant.

<b>NAME</b>
<b>STREET ADDRESS (include city, state and ZIP)</b>

**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 Oklahoma Pharmacy Act. I agree to comply with the Oklahoma 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

- Please allow 2-3 weeks for processing and mailing of your license. Verification of receipt will not be done over the telephone. You may request verification that your renewal application was received by enclosing a self-addressed, stamped envelope (**SASE**) marked "**COPY**".
- A separate **SASE** marked "**MAIL ADDRESS**" must be enclosed for licenses requiring delivery to a mailing address other than the address listed in Section A.