OKLAHOMA STATE BOARD OF PHARMACY

4545 Lincoln Blvd, Ste 112, Oklahoma City, OK 73105-3488
Phone: (405) 521-3815 / Fax: (405) 521-3758
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APPLICATION FOR PHARMACY

√ CHECK ALL THAT APPLY		
		NEW PHARMACY
		CHANGE OF OWNERSHIP
		CHANGE OF LOCATION
		CHANGE OF NAME

FOR OSBP USE ONLY				
LICENSE	ISSUED	RECEIPT	DATE	REPLACES

A. Type of Pharmacy (√ one) **Fee must be enclosed with application**				
		CHARITABLE (In-State)	$175	Policies & Procedures Attached ___ Yes ___ No
		HOSPITAL (In-State)	$250	# BEDS _______
		HOSPITAL DRUG ROOM (In-State)	$140	# BEDS _______
		NON-RESIDENT (Out-of-State)	$150	★ Must Attach Copy of Resident State License
		RETAIL (In-State) [√ type]	$250	Independent ☐ Chain ☐ Clinic ☐ / Closed Door ☐ Nuclear ☐ Other__________

B. Pharmacy Name, DBA *(if applicable)* and Address:

____

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C. Type of Ownership **(√ one and attach the appropriate form to this application)**		
		INDIVIDUAL ***(complete Form A)***
		PARTNERSHIP ***(complete Form A)***
		CORPORATION ***(complete Form B1 or B2)***
		LLC ***(complete Form C)***
		GOVERNMENT ***(complete Form D)***

D. Located in ______________________ county. e-mail: ______________________________

Phone: ( ) ____________ ★Toll Free: ( ) ____________ Fax: ( ) ____________

Pharmacy hours: Mon - Fri ________ Saturday _________ Sunday ________ [★ required for non-resident]

★ **Florida applicants:**

1. List Name & Address of Primary Wholesaler:
   ____
2. Is original issue date of pharmacy within 60 days of this application? **Yes**☐ **No** ☐ **If YES,** attach a copy of the opening inventory invoice.

E. **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. I certify that I am a licensed pharmacist in the state of ___________________. 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: *(if applicable)*

Printed Name & Title: ____ (DPh, RN or LPN)

F. The following licensed **Pharmacists and Technicians** are also 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√**

LICENSE EXPIRES ANNUALLY – 12 MONTHS FROM ISSUE DATE

G. 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.

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.

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.	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? *(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.)*	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? *(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.)*	Yes [ ] No [ ]
4.	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? *(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.)*	Yes [ ] No [ ]
5.	Has the applicant ever had any application for a license or permit refused or denied by any licensing authority?	Yes [ ] No [ ]
6.	Has the applicant ever had a registration issued by a controlled substance authority revoked, suspended, surrendered, limited, or restricted?	Yes [ ] No [ ]

NOTE: If the business entity is organized pursuant to the laws of any jurisdiction other than the State of Oklahoma, the business entity must qualify (or register) to do business in Oklahoma by filing the appropriate forms with the Oklahoma Secretary of State.

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

____

Print Name & Title of Owner / Managing Officer

Subscribed and sworn to before me this ______ day of ____________________________ , 20 _____ .

____

Notary Public

Please attach the appropriate fee and corresponding ownership form as noted in Sections A and C. Applications are processed upon receipt. Please allow 2-3 weeks for processing of your license and, if applicable, physical inspection of your pharmacy. (Note: physical inspection will occur for all in-state pharmacies)

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