

Make Check Payable to:
**Treasurer, State of New
Hampshire**

**STATE OF NEW HAMPSHIRE
BOARD OF PHARMACY**
7 Eagle Square, Suite 300
Concord, NH 03301
(603) 271-2350 Fax: (603) 271-2856
www.oplc.nh.gov/pharmacy

APPLICATION FOR PERMIT TO CONDUCT A PHARMACY IN NEW HAMPSHIRE

Type of Application:

New Pharmacy / Original Application - **\$500.**

Estimated Date of Opening: _____

Change of Pharmacy Name - **\$250.**

Effective Date of Change: _____

Change of Location - **\$250.**

Estimated Date of Move: _____

Change of Ownership - **\$250.**

Estimated Date of Change: _____

Change of Pharmacist-In-Charge - **\$250.**

Effective Date of PIC Change: _____ Name of Former PIC: _____

PHARMACY INFORMATION

Name of Pharmacy

Street Address of Pharmacy

City/Town

State

Zip Code

NH

Telephone Number

Fax Number

E-Mail Address (Must be entered to receive permit)

DEA Number

Expiration Date

PHARMACIST-IN-CHARGE STATEMENT

I, _____, of _____
Designated Pharmacist Home Address (Not P.O. Box)

_____, do hereby agree to serve as
City/Town State Zip Code

pharmacist-in-charge at the above pharmacy.

TYPE OF PHARMACY

This application is for a permit to conduct a: (check one)

- Community Pharmacy ⇒ If community pharmacy, licensing: Entire Store Area Pharmacy Dept. Only
- Hospital Pharmacy (For Profit) Home Infusion Pharmacy
- Other (Specify) _____

TYPE OF OWNERSHIP

(Check One)

- Sole Proprietorship Partnership Corporation LLC

(Check One)

- For Profit Non-Profit

- If **non-profit organization**, and **IRS tax exempt**, attach a copy of the 501(c)(3) exemption approval issued by the U.S. Internal Revenue Service for each applicable entity.
- In the case of non-501(c)(3) organizations, attach a disclosure listing of **any practitioner ownership** which is not exempt as a "passive investment acquired at open market terms". (practitioner means any person lawfully entitled to prescribe medicine, or such person's spouse or dependent children).

If a **sole proprietorship**, list the name, official address, and occupation/business of owner:

If a **partnership**, list the name, official address, and occupation/business of each partner and the percentage of ownership held by each partner:

If any partner is a corporation, that partner shall **also** provide the information required of corporations below.

If a **corporation** (list, the following):

Corporation name and date and state of incorporation:

If applicable, date of filing with the State of New Hampshire as a foreign corporation:
(attach copy of authorization issued by the NH Secretary of State)

Address of principal place of business:

CORPORATE INFORMATION (CONTINUED)

Name, address, & telephone number of **agent of record**, in New Hampshire, for service of process:

List each type, or class, of voting stock and the number of shares authorized and outstanding for each class:

- Provide as a supplement to this application, the name, address, corporate title, occupation and percentage of stock held for all corporate officers/directors, and of all holders of 5% or more of each class of voting stock.
- If a listed shareholder is itself a corporation, provide the same for each such corporation.
- If a listed shareholder is a partnership, provide the information required under the partnership section on page 2 for each such partnership.
- Provide as a supplement to this application, the disclosure of the corporate structure, including parent company or companies.

LEGAL PROCEEDINGS/ACTIONS

To your knowledge, have there been or are there now pending any indictments of any nature or any alleged violations of the law governing the practice of pharmacy, controlled substances, or other regulated drugs against the corporation, members of the corporation or partnership, or any of the individuals named in this application?

Yes No (If yes, attach explanation)

To your knowledge, have any of the above individuals/entities been convicted of a local, state, or federal drug or pharmacy law?

Yes No (If yes, attach explanation)

To your knowledge, have any of the above individuals/entities been convicted of a felony within the past 10 years?

Yes No (If yes, attach explanation)

PHARMACY HOURS OF OPERATION

This pharmacy shall be open a total of _____ hours per week and available to provide professional services during the following time periods:

MON. _____ to _____ TUES. _____ to _____ WED. _____ to _____

THUR. _____ to _____ FRI. _____ to _____

SAT. _____ to _____ SUN. _____ to _____

*Note: There must be pharmacist coverage (as noted in next section) for all hours the pharmacy is open.

PHARMACISTS TO BE EMPLOYED AT PHARMACY

(Including Owner/Manager, If A Licensed Pharmacist – Attach additional sheet if necessary)

PHARMACIST NAME	NH LICENSE #	HOURS/WEEK

PHARMACY TECHNICIANS TO BE EMPLOYED AT PHARMACY – Attach additional sheet if necessary

TECHNICIAN NAME	NH TECHNICIAN REG. #

GENERAL PHARMACY INFORMATION/SPECIFICATIONS

What are the dimensions of that portion of the pharmacy devoted to the preparation of prescriptions?

_____ Enter either total square footage or dimension (length x width)

Give a brief description of the pharmacy department. (Complete **only** if this is an original application for a new pharmacy **or** if changes have occurred to an existing pharmacy)

GENERAL PHARMACY INFORMATION/SPECIFICATIONS (Continued)

List persons (names & titles) who have security access to the pharmacy [according to Ph 303.02(m) and Ph 702.05(b)].

PHARMACY OWNER / CORPORATE REPRESENTATIVE AFFIDAVIT

As chief administrative officer of _____, I certify that
Corporation/Partnership

_____ is designated by me as pharmacist-in-charge to operate
Name of Pharmacist
this pharmacy in compliance with all federal, state, and local laws. I have read this application and all of the statements made on it are, to the best of my knowledge, true and correct. As the owner or corporate representative of this pharmacy, my signature below acknowledges my (the corporation's) responsibilities as the permit holder, including all of the corporate / permit holder duties and responsibilities noted in NH RSA 318:38 and Ph 704.11(d).

Signature of Company / Corporate Representative _____
Title _____
Date

PHARMACIST-IN-CHARGE AFFIDAVIT

PHARMACIST-IN-CHARGE AFFIDAVIT

I swear and affirm that the answers and statements made on this application are true and correct to the best of my knowledge and belief, that this pharmacy has the required facilities and equipment and meets the conditions specified by the Board of Pharmacy, a copy of whose laws and rules I have read. I agree to replace promptly any item on the required equipment list which becomes lost, broken, or otherwise becomes unfit for use. I also agree to display the pharmacy permit in a conspicuous place in this pharmacy. I understand that this permit is issued to the pharmacy in the name of the corporation or the owner of the pharmacy. Upon my termination as pharmacist-in-charge this permit is not transferable; and upon any change in partnership composition; or upon the acquisition of the existing corporation by any person; or change in controlling interest in the corporation; or should the pharmacy be moved or closed or if the premises are damaged by fire or otherwise, this permit shall be immediately surrendered to the Board of Pharmacy.

I further agree to operate this pharmacy in accordance with all federal, state, and local pharmacy/drug laws and regulations.

Signature _____
Date