

APPLICATION FOR IOWA PHARMACY LICENSE

Please type or print clearly in ink. Make changes as necessary.

1 CLASSIFICATION: GENERAL PHARMACY HOSPITAL PHARMACY LIMITED USE PHARMACY

2 APPLICATION FOR:

Renewal New Address Chg. Name Chg. Ownership Chg. Pharmacist in Charge Chg.

FOR LICENSE PERIOD:

IOWA PHARMACY LICENSE NO.:

LICENSE FEE: \$135.00

3 DBA, LEGAL NAME, & LOCATION OF PHARMACY:

Name _____

Address _____

City,State,Zip _____

County _____

Remit check or money order payable to:

IOWA BOARD OF PHARMACY

(DO NOT SEND CASH)

4 PHARMACY PHONE (_____) _____ **FAX** (_____) _____

E-MAIL ADDRESS: _____ **FED.TAX ID:** _____

5 TYPE OF OWNERSHIP: Individual Partnership Corporation Other _____

6 Pharmacist in Charge:

NAME

LICENSE NO.

HRS WORKED/WK

SIGNATURE

7 ATTACH THE FOLLOWING INFORMATION:

- a) List of the names, titles, and addresses of all principal owners, partners, and officers of the pharmacy.
- b) List of all staff pharmacists currently employed (*include pharmacist license number and average hours worked per week for each*).
- c) List of all technicians and pharmacy support persons currently employed (*include individual registration number, type of registration, and average hours worked per week for each*).
- d) A typed description of the prescription drugs and services provided by the pharmacy.

8 CRIMINAL HISTORY

Has the pharmacy, the pharmacy's owner, or any officer or partner (if the pharmacy is owned by a corporation or partnership), the pharmacist in charge, any pharmacist, any pharmacy technician, or any pharmacy support person ever been convicted of any crimes (felonies or misdemeanors)? *Exclude traffic violations and alcohol-related offenses classified as misdemeanors.*

_____ Yes _____ No *If yes, attach explanation.*

9 DISCIPLINARY HISTORY: (NOTE: Discipline includes, but is not limited to: citations, reprimands, fines, license restrictions, probation, and license or registration surrender, suspension, and revocation.)

- a) Has the pharmacy, the pharmacy's owner, or any officer or partner (if the pharmacy is owned by a corporation or partnership), the pharmacist in charge, any pharmacist, any pharmacy technician, or any pharmacy support person ever been disciplined by any licensing authority?

_____ Yes _____ No *If yes, describe the discipline and attach all relevant disciplinary documents. Documents related to discipline by the Iowa Board of Pharmacy need not be attached.*

- b) Does the pharmacy, the pharmacy's owner, any officer or partner, the pharmacist in charge, any pharmacist, any pharmacy technician, or any pharmacy support person have any charges, or knowledge of any complaints or investigations, pending before any licensing authority?

_____ Yes _____ No *If yes, attach explanation.*

c) Has the pharmacy, the pharmacy's owner, any officer or partner, the pharmacist in charge, any pharmacist, any pharmacy technician, or any pharmacy support person ever been denied a license or registration by any professional licensing authority?

_____ Yes _____ No *If yes, attach explanation.*

10 PHARMACY INFORMATION:

a) What are the regular hours of operation of the pharmacy for each period/day identified?

Monday-Friday: _____ Saturday: _____ Sunday: _____

b) Is the pharmacy registered with the DEA as a controlled substance collector? _____ Yes _____ No

c) What type of pharmacy do you operate? *(Check all that apply.)*

- Community Home infusion Nuclear Central Rx processing Hospital
- Mail order Long-Term Care Internet Central Rx filling Other *(explain)*

d) Which of the following populations does the pharmacy serve? *(Check all that apply.)*

- Human Veterinary—companion animals Veterinary—food-producing animals

e) Which of the following accreditations does the pharmacy have? *(Check all that apply.)*

- VPPS VIPPS PCAB ACHC JCAHO DMEPOS Other _____ None

f) Does the pharmacy engage in compounding? _____ Yes _____ No

If yes, what types? (Check all that apply.)

- Sterile High-Risk Sterile Medium-Risk Sterile Low-Risk
- Non-sterile Pursuant to patient-specific Rx In anticipation of patient-specific Rx
- For hospital use For office use by prescriber

g) Does the pharmacy dispense or intend to dispense controlled substances?

_____ Yes _____ No

If yes, does the pharmacy hold current, valid DEA registration and Iowa CSA registration:

_____ Yes _____ No

(Pharmacies are required to report to Iowa's Prescription Monitoring Program (PMP), including submission of zero reports. Please be aware of the reporting requirements described in 657 Iowa Administrative Code chapter 37 and the Iowa Data Reporting Manual.)

11 FDA INFORMATION:

a) Has the pharmacy ever been inspected by the FDA? _____ Yes _____ No

b) If yes, date of last inspection: _____

c) If yes, has the FDA ever issued a 483 or a warning letter to the pharmacy? _____ Yes _____ No

If yes, please attach the FDA documentation and include documentation regarding your pharmacy's response to the FDA.

d) Is the pharmacy registered with the FDA as a 503(b) outsourcing facility? _____ Yes _____ No

REMIT TO: IOWA BOARD OF PHARMACY
400 S.W. EIGHTH STREET, SUITE E
DES MOINES, IA 50309-4688
PHONE: (515) 281-5944

Information provided on
this application may be
disclosed pursuant to
657 IAC Chapter 14.

I hereby swear under penalty of perjury that the information provided in this application is true and correct. I understand that failure to provide complete and truthful information may constitute grounds for denial, revocation, or other disciplinary sanctions against the pharmacy's license and the pharmacist in charge's license.

**12
SIGN
HERE** 

Signature of Owner or Corporate Officer

Title

Date

INCOMPLETE APPLICATIONS WILL NOT BE ACCEPTED AND WILL BE RETURNED TO APPLICANT