APPLICATION FOR IOWA PHARMACY LICENSE

Please type or print clearly in ink. Make changes as necessary FOR LICENSE PERIOD 01/01/2017 through 12/31/2017

1 TYPE: ☐ GENERAL ☐ HOSPITAL ☐ LIMITED USE Type _____

2 PURPOSE: ☐New ☐Renewal - Applications for renewal will not be accepted before November 1.
☐Change TYPE: ☐Pharmacist in Charge ☐Address ☐Name ☐Ownership

3 PHARMACY INFORMATION:

DBA: _____
Legal Name: _____
Address: _____
_____
_____
_____

County: ____
IOWA PHARMACY LICENSE NO.: ____

LICENSE FEE: $135.00 *
*Fee for License renewal between
Jan 1 and Jan 31 = $270.00
Feb 1 and Feb 29 = $360.00
Mar 1 and Mar 31 = $450.00
April 1 or later = $540.00
Remit check/money order payable to:
IOWA BOARD OF PHARMACY
(DO NOT SEND CASH)

PHONE: (____) _____ FAX: (____) _____
E-MAIL: _____ FED.TAX ID: _____

4 TYPE OF OWNERSHIP: ☐Individual ☐Partnership ☐Corporation ☐LLC ☐Other _____

5 PHARMACIST IN CHARGE:_____ License #_____

6 HOURS: Monday-Friday _____ Saturday _____ Sunday _____

7 SERVICES: *Check all that apply*
☐Home infusion ☐Nuclear ☐Central Rx processing ☐Mail order ☐Long-Term Care ☐Internet
☐Central Rx filling ☐Veterinary — ☐companion animals ☐food-producing animals
☐Other (explain) _____

8 CONTROLLED SUBSTANCES:
Does the pharmacy dispense controlled substances? YES NO
Is the pharmacy reporting to the Prescription Monitoring Program (PMP)? YES NO

9 REGISTRATIONS: *Check all that apply*
☐None ☐DEA #_____ ☐CSA #_____ ☐FDA 503B Outsourcing Facility #_____

10 ACCREDITATIONS: *Check all that*
☐None ☐VPP ☐VIPPS ☐PCAB ☐ACHC ☐JCAHO ☐DMEPOS
☐Other_____

11 COMPOUNDING: *Check all that apply*
☐None ☐Non-sterile ☐Sterile- risk level: _____ ☐For hospital use ☐For office use
☐Pursuant to patient-specific Rx ☐In anticipation of patient-specific Rx

Number of sterile compounded products shipped/mailed/delivered out of the state of Iowa last year? _____
List States_____
Has FDA inspected this pharmacy? YES NO
Has the pharmacy EVER been issued a Warning Letter by the FDA? YES NO
If you answered yes to any FDA question, attach a copy of the inspection report/letter and the pharmacy's response.

12 CRIMINAL HISTORY *includes felonies and/or misdemeanors, and deferred judgments*

	PLEASE	CIRCLE
Since the last renewal, have any of the following been convicted or received a deferred judgment of any crimes?		
a) The pharmacy or the pharmacy's owner (individual, partnership, corporation, LLC)	YES	NO
b) Any pharmacist including the pharmacist in charge	YES	NO
c) Any pharmacy technician or pharmacy support person	YES	NO
Since the last renewal, are any of the following under investigation of any crimes?		
a) The pharmacy or the pharmacy's owner (individual, partnership, corporation, LLC)	YES	NO
b) Any pharmacist including the pharmacist in charge	YES	NO
c) Any pharmacy technician or pharmacy support person	YES	NO

If you answered yes to any question above, provide a description and all legal documents.

13 DISCIPLINARY HISTORY *includes, but is not limited to: citations, reprimands, fines, license or registration restrictions, probation, surrender, suspension, and revocation*

	PLEASE CIRCLE	
Since the last renewal, have any of the following been disciplined by any health licensing authority?		
a) The pharmacy or the pharmacy's owner (individual, partnership, corporation, LLC)	YES	NO
b) Any pharmacist including the pharmacist in charge	YES	NO
c) Any pharmacy technician or pharmacy support person	YES	NO
Since the last renewal, are any of the following under investigation by any health licensing authority?		
a) The pharmacy or the pharmacy's owner (individual, partnership, corporation, LLC)	YES	NO
b) Any pharmacist including the pharmacist in charge	YES	NO
c) Any pharmacy technician or pharmacy support person	YES	NO

If you answered yes to any question above, provide a description and all administrative documents.

14 ATTACH THE FOLLOWING INFORMATION:

a) A typed description of all of the services provided by the pharmacy.
b) Names, titles, and addresses of all principal owners, partners, and officers of the pharmacy.
c) Names, titles, license/registration numbers and average hours worked per week for all pharmacists (including PIC), technicians, and pharmacy support persons currently employed.

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

15 REQUIRED SIGNATURES

Signature of Pharmacist in Charge *Date*

Signature of Owner or Corporate Officer *Title* *Date*

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

INCOMPLETE APPLICATIONS WILL BE RETURNED TO APPLICANT