

West Virginia Board of Pharmacy

1207 Quarrier St, 4th Floor, Charleston, WV 25301 Phone: 304 558 0558 Fax: 304 558 0572

NEW PHARMACY PERMIT APPLICATION

(Out of State/Non-Resident Pharmacy Applicants use Mail Order

Application) Submit floor plan to scale with this form. (Must show counseling area, Rx in & Rx out including cash register) Additional \$250.00 fee applies if inspection is requested with less than 7 days notice.

Additional \$250.00 fee applies if re-inspection is required.

All numbered lines must be completed or application will be returned for completion.

1. Name of Pharmacy to be permitted _____ Date _____
2. Physical address _____ Mailing address _____
City _____ State _____ Zip _____ County _____
3. Pharmacy e-mail address _____
4. Pharmacist-in-charge _____ RP _____
5. Pharmacist-in-charge work phone prior to opening _____ Home Phone _____
6. Has your pharmacist license ever been denied, suspended, or revoked in this or any state? Yes ___ No ___
7. Have you ever been convicted of a felony? Yes ___ No ___
8. Have you ever been convicted of a misdemeanor other than a traffic violation? Yes ___ No ___
9. If any answer on 6 thru 8 is yes attach a detailed explanation.
10. Type of ownership? (check one) Single Proprietor ___ Partnership ___ Corporation ___
11. Is this pharmacy owned as a sole/single-site pharmacy or as part of a multi-site pharmacy group or chain?
12. Names of principals and their titles: (owner, partners, three corporate officers)

13. Has the applicant or any officer or partner ever been convicted of a felony?

14. Circle applicable fees:

- | | | |
|--------------------------------|----------|--------------------------------------|
| a. Pharmacy in-patient | \$150.00 | |
| b. Pharmacy out-patient | \$150.00 | |
| c. Controlled Substance Permit | \$10.00 | |
| d. Sterile Compounding Permit | \$150.00 | |
| e. Nuclear Pharmacy Permit | \$150.00 | (Note d. & e. also require a. or b.) |

15. Attach check or money order to application Total Fees _____

16. Circle applicable Controlled Drug Schedules applied for II III IV V

17. Name & work address of person(s) with Controlled Substance Power of Attorney:

18. The undersigned herby swear or, affirm, that all statements made herein are true and correct, and that all provisions of the law and regulations relative to the practice of pharmacy, will be faithfully observed so long as any permit issued.

19. _____
Signature of applicant, managing partner, or officer Date

20. _____
Signature of pharmacist-in-charge Date