PENNSYLVANIA STATE BOARD OF PHARMACY
PO BOX 2649
HARRISBURG, PA 17105-2649

(717) 783-7156
www.dos.pa.gov/pharm
st-pharmacy@pa.gov

NONRESIDENT PHARMACY APPLICATION FOR A CHANGE IN LOCATION, CHANGE IN OWNERSHIP OR CHANGE IN TITLE

(#854 143, Rev. 6/19)

Instructions:

1. Make check or money order payable to the "Commonwealth of PA." Fees are not refundable. Fee amounts are listed on the first page of the application.

   Note: If for any reason a check or money order is returned unpaid by your bank, regardless of the reason for non-payment, a processing fee of $20.00 will be charged.

2. Mail completed application and supporting documentation to:

Mailing Address: (USPS)	***Courier*** Address: (UPS, FED-EX, etc.)
PO Box 2649	PA Dept of State
Harrisburg, PA 17105-2649	Bureau of Professional and Occupational Affairs
	Attn: State Board of Pharmacy
	2 Technology Park
	Harrisburg, PA 17110-2919

3. **Additional documentation required:**

   a. **New nonresident pharmacy registration** applications are now available online at www.pals.pa.gov. Please utilize this web site to submit an application for a new nonresident pharmacy registration; paper applications will no longer be accepted.

   b. For a **change in location and/or change in title**, along with the application and application fee:

      A. Make sure to complete the change in location and/or change in title section(s). You do not need to complete the "Disciplinary Action History – Pharmacy" section and the "Ownership Information" section UNLESS you have information to report for these sections that was not previously reported to the Pennsylvania State Board of Pharmacy.
      B. Submit documentation (ex. photocopy of new pharmacy permit, photocopy of an approval letter) indicating that the board of pharmacy in the state in which the pharmacy is located has approved this change.

   c. For a **change in ownership**, along with the application and application fee:

      A. Make sure to complete the change in ownership section. You do not need to complete on application page 3 the "Toll Free Phone Number" and the "Disciplinary Action History – Pharmacy" sections UNLESS you have information to report for these sections that was not previously reported to the Pennsylvania State Board of Pharmacy.
      B. Submit documentation (ex. photocopy of new pharmacy permit, photocopy of an approval letter) indicating that the board of pharmacy in the state in which the pharmacy is located has approved this change.

Information:

1. A nonresident pharmacy may not engage in the business of shipping, mailing or delivering legend devices or legend drugs in the Commonwealth of Pennsylvania unless the nonresident pharmacy has been issued a certificate of registration by the Pennsylvania State Board of Pharmacy.

2. If a pending application is older than one year from the date submitted and the applicant wishes to continue the application process, the Board shall require the applicant to submit a new application including the required fee. In order to complete the application process, many of the supporting documents associated with the application cannot be more than six months from the date of issuance.

3. A nonresident pharmacy shall report to the Pennsylvania State Board of Pharmacy within thirty days of final disposition any disciplinary action taken by the regulatory or licensing agency of the state in which the nonresident pharmacy is located.

4. It is your responsibility to maintain a copy of this and all documents submitted to the Pennsylvania State Board of Pharmacy (Board) or received from the Board for your future reference.

5. All nonresident pharmacy registrations will expire on the same date – August 31 of odd-numbered years.

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Choose the transaction type by checking the appropriate box:

- ☐ Change in location of a registered nonresident pharmacy - $45.00 fee
- ☐ Change in ownership of a registered nonresident pharmacy - $30.00 fee
- ☐ Change in title (pharmacy name) of a registered nonresident pharmacy - $45.00 fee

Note: **New nonresident pharmacy** registration applications are now online at www.pals.pa.gov.

Make check or money order payable to the "Commonwealth of PA."

If the pharmacy already holds a Pennsylvania Nonresident Pharmacy Registration, please provide the Pennsylvania Nonresident Pharmacy Registration number:
NP_____

Name of pharmacy as registered in your ***resident*** state:
(Must match resident state pharmacy permit)

_____

Pharmacy permit/license number in your ***resident*** state:_____
(Must match resident state pharmacy permit)

Pharmacy's address as registered in your ***resident*** state:
(Must match resident state pharmacy permit)

Street:_____

City:_____State:_____Zip Code:_____

Pharmacy's E-mail Address:_____

Contact Person's Name:_____

Contact Person's Mailing Address:

Street:_____

City:_____State:_____Zip Code:_____

Contact Person's E-Mail Address:_____

Change in Location of a Registered Nonresident Pharmacy

If ***reporting a change in location*** for a Pennsylvania-registered nonresident pharmacy, please provide below the former pharmacy address and the date that the pharmacy relocated. Also submit documentation (ex. photocopy of new pharmacy permit, photocopy of an approval letter) indicating that the board of pharmacy in the state in which the pharmacy is located has approved this change. Page one of this application should reflect the new address.

Provide the Pharmacy's Former Address:

Former Street:_____

Former City:_____State:_____Zip Code:_____

Relocation Date in Month/Day/Year Format:_____

Change in Title (Pharmacy Name) of a Registered Nonresident Pharmacy

If ***reporting a change in title*** for a Pennsylvania-registered nonresident pharmacy, please provide below the former pharmacy title (name) and the date that the title changed. Also submit documentation (ex. photocopy of new pharmacy permit, photocopy of an approval letter) indicating that the board of pharmacy in the state in which the pharmacy is located has approved this change. Page one of this application should reflect the new title.

Former Pharmacy Title (Name):_____

Effective Date of the Title (Name) Change in Month/Day/Year Format:_____

Change in Ownership of a Registered Nonresident Pharmacy

If ***reporting a change in ownership*** for a Pennsylvania-registered nonresident pharmacy, please provide below the former pharmacy owner's name and the date that ownership changed. Also complete the ownership information page for the new owner.

Name of Former Owner:_____

Effective Date of the Ownership Change in Month/Day/Year Format:_____

Pharmacist in Charge Information

Printed name of *current* pharmacist in charge (PIC): _____

PIC's address:_____

PIC's *resident state* pharmacist license number:_____

Toll Free Phone Number

- Provide the toll free telephone number that will be used for communication between Commonwealth of PA patients and the pharmacy:

  _____

  Note: The toll free phone number listed here must match the toll free number printed on the prescription label.

Disciplinary Action History – Pharmacy

Has the nonresident pharmacy named in this application been subject to suspension or revocation or otherwise disciplined by the proper licensing authority of another state?

Check the appropriate response. ☐ Yes ☐ No

If "Yes":

1. Provide a letter of explanation with the application.

2. Arrange for the licensing authority to submit directly to the Pennsylvania State Board of Pharmacy a **certified** copy of the disciplinary action.

Ownership Information

Please complete only ONE of the following sections with regard to the ownership of this pharmacy:

Federal Employer Identification Number (FEIN): _____

Full Name of Corporation: _____

Principal Officer: _____
NAME ADDRESS TITLE

Principal Officer: _____
NAME ADDRESS TITLE

Principal Officer: _____
NAME ADDRESS TITLE

Principal Officer: _____
NAME ADDRESS TITLE

Federal Employer Identification Number (FEIN): _____

Full Name of Limited Liability Company: _____

Principal Officer: _____
NAME ADDRESS TITLE

Principal Officer: _____
NAME ADDRESS TITLE

Principal Officer: _____
NAME ADDRESS TITLE

Federal Employer Identification Number (FEIN): _____

Full Name of Partnership: _____

Principal Officer: _____
NAME ADDRESS TITLE

Principal Officer: _____
NAME ADDRESS TITLE

Principal Officer: _____
NAME ADDRESS TITLE

☐ Please check here if one of the above scenarios does not apply. Please provide an explanation on a separate attachment. Along with your detailed explanation, provide the Federal Employer Identification Number (FEIN), the name of the owner, and the names, addresses and titles for all of the principal officers.

Verification Statement

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

I agree to notify the Board within 30 days in the event that the nonresident pharmacy named in this application changes location or changes pharmacist in charge.

I verify that the nonresident pharmacy named in this application will comply with all lawful directions and requests for information from the regulatory or licensing agency of the state in which it is licensed as well as comply with all requests for information made by the Pennsylvania State Board of Pharmacy.

I verify that the nonresident pharmacy named in this application maintains a valid, unexpired license, permit or registration to conduct the pharmacy in compliance with the laws of the state in which the nonresident pharmacy is located.

I verify that the nonresident pharmacy named in this application shall, during its regular hours of operation, but not less than six days per week, and for a minimum of forty hours per week, provide a toll-free telephone number to facilitate communication between patients in the Commonwealth of Pennsylvania and a pharmacist who is licensed in the Commonwealth of Pennsylvania or in the state in which the nonresident pharmacy is located and who has access to the patient's records. I verify that this toll-free telephone number shall be disclosed on a label **affixed to** each container of drugs dispensed to patients in the Commonwealth of Pennsylvania.

In the event that this application was submitted for the purpose of obtaining a ***new nonresident pharmacy registration***, I verify that the enclosed photocopied inspection report is the most ***recent*** inspection report from the regulatory or licensing agency of the state in which the nonresident pharmacy is located or by the National Association of Boards of Pharmacy's Verified Pharmacy Program.

_____ _____

Signature of the Pharmacist in Charge — Date (month/day/year format)
Only original signatures are acceptable

_____

Printed Name of Pharmacist in Charge

AND

_____ _____

Signature of the Owner's Authorized Representative — Date (month/day/year format)
Only original signatures are acceptable

Title:_____

Printed Name:_____