PCY Rev 8/18

**STATE OF CONNECTICUT**
**DEPARTMENT OF CONSUMER PROTECTION**
DRUG CONTROL DIVISION
COMMISSION OF PHARMACY
Email: dcp.pharmacylicense@ct.gov
Website: www.ct.gov/dcp

For Official Use Only

# APPLICATION FOR A CHANGE OF LOCATION FOR AN IN-STATE PHARMACY

**INSTRUCTIONS:**

This completed application and all required attachments must be submitted no later than fifteen (15) days prior to the next regularly scheduled Commission of Pharmacy meeting. Only complete applications will be added to the agenda. To confirm the date and time of the next available Commission of Pharmacy meeting, please email dcp.pharamcycomission@ct.gov.

1. All spaces must be completed on this form.
2. This application must be accompanied by a check or money order in the amount of **$190.00** made payable to "*Treasurer, State of Connecticut.*" Application fees are non-refundable.
3. Attach a 8.5" x 11" paper copy of the blueprint of the new facility.
4. Attach a copy of the updated prescription label.
5. If applicable, complete the appropriate change forms as needed based on the changes to your business.
6. Mail this completed application, fee and required attachments to:
   Department of Consumer Protection, License Services Division, 450 Columbus Blvd, Ste. 801, Harford, CT 06103

## Pharmacy Information

| Pharmacy Name | | | CT Pharmacy License # |
|---|---|---|---|
| Current Street Address | City | State | Zip Code |
| Telephone Number | Email Address to be used for all correspondence | | |

## New Location Information

| New Location Street Address | City | State | Zip Code |
|---|---|---|---|
| Contact Person Name and Title to Schedule Inspection | | | |
| Contact Person Telephone Number | Email Address to Schedule Inspection | | |

| Anticipated Construction Date | Anticipated Completion Date | Anticipated Inspection Date | Anticipated Opening Date |
|---|---|---|---|
| | | | |

| **Pharmacy Hours**: | **Store Hours**: |
|---|---|
| Monday – Friday: Open:_____ Close:_____ | Monday – Friday: Open:_____ Close:_____ |
| Saturday: Open:_____ Close:_____ | Saturday: Open:_____ Close:_____ |
| Sunday: Open:_____ Close:_____ | Sunday: Open:_____ Close:_____ |

## Certification

By signing this form, I certify the new location is in compliance with zoning ordinances and by-laws of the city/town and that the information contained in this application is the truth to the best of my knowledge and have attached all of the documents required that are applicable to this license.

| Printed Name of New Pharmacy Manager | |
|---|---|
| Signature of New Pharmacy Manager | Date |