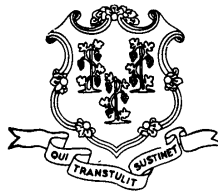


STATE OF CONNECTICUT
DEPARTMENT OF CONSUMER PROTECTION
DRUG CONTROL DIVISION
COMMISSION OF PHARMACY
 Email: dcp.pharmacylicense@ct.gov
 Website: www.ct.gov/dcp



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.pharmacycomission@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, Hartford, 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:

Monday – Friday: Open: _____ Close: _____
 Saturday: Open: _____ Close: _____
 Sunday: Open: _____ Close: _____

Store Hours:

Monday – Friday: Open: _____ Close: _____
 Saturday: 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