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 NEW CONNECTICUT IN-STATE PHARMACY

INSTRUCTIONS:

This completed application and all required documents 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 obtain the date and time of the next available Commission of Pharmacy meeting, email dcp.pharmacycommission@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 **$750.00** made payable to "*Treasurer, State of Connecticut.*" Application fees are non-refundable.
3. Attach a list of all officers/directors, individuals or partners associated with the ownership of this pharmacy with their first and last name and address. Note: A prescribing practitioner may not have an ownership interest.
4. Attach a copy of your prescription label.
5. Attach an 8.5" x 11" paper copy of the blueprint of the facility.
6. Attach a list of all pharmacists with their address and license number.
7. Mail the completed application, fee and required attachments to:
   Department of Consumer Protection, License Services Division, 450 Columbus Blvd, Ste. 801, Hartford, CT 06103

Pharmacy Information

New Pharmacy Name			
Pharmacy Location Address	City	State	Zip Code
Pharmacy Telephone Number	Email Address to be used for all correspondence		
FEIN	National Provider Identifier (NPI) #		

Type of Pharmacy: ☐ Community ☐ Infusion Therapy/Sterile Compounding ☐ Long –Term Care ☐ Nuclear ☐ Specialty

Pharmacy Manager

Name of Pharmacy Manager	CT Pharmacist License #

1. Has the above pharmacy manager appeared before the Commission of Pharmacy as a first time manager? ☐ Yes ☐ No
   If No, please email dcp.pharmacycommission@ct.gov to request to appear before the Commission of Pharmacy.

Mailing Address (if different than above)

Name			
Street Address	City	State	Zip Code

Owner Information

Type of Business: ☐ Individual/Sole Proprietorship ☐ Corporation ☐ Limited Liability Company ☐ Partnership

Name of Owner			
Business Address	City	State	Zip Code
Telephone Number	Email Address		

1. Has the applicant, partner or member of the board of directors ever been convicted of a felony crime? ☐ Yes ☐ No If Yes, attach a statement including the date(s) of the conviction(s), the courts(s) where the case(s) were decided and a description of the circumstances involved.

Pharmacy Inspection Contact

Contact Person Name and Title to Schedule Inspection			
Contact Person Telephone Number	Contact Person Email Address		
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.

Print Name and Title	
Signature	Date