PCN-5/13

STATE OF CONNECTICUT
**DEPARTMENT OF CONSUMER PROTECTION**
DRUG CONTROL DIVISION
COMMISSION OF PHARMACY
Telephone: (860) 713-6070
Website: www.ct.gov/dcp/cop/
Email: DCP.PharmacyLicense@ct.gov

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# APPLICATION FOR REGISTRATION OF NONRESIDENT PHARMACY

**Instructions**: Please complete this application and submit it with a **fee via check or money order for $750.00** made payable to "*Treasurer, State of Connecticut*". **Application fees are non-refundable.**
This application should be mailed to:
*Department of Consumer Protection, License Services, 165 Capitol Ave, Hartford, CT 06106*

| Pharmacy Name | | | |
|---|---|---|---|
| Pharmacy Street Address | City | State | Zip |
| Mailing Address (if different from the address above) | City | State | Zip |

| Telephone number (w/ area code) | FEIN | Email Address |
|---|---|---|
| | | |

| Pharmacist Manager Name | Pharmacist Manager License # | Email Address |
|---|---|---|
| | | |

| Street Address of the Pharmacist Manager | City | State | Zip |
|---|---|---|---|
| | | | |

| Toll Free Number of the Pharmacy | Hours of Operation | | |
|---|---|---|---|
| Website | Monday-Friday | Open | Close |
| | Saturday | Open | Close |
| | Sunday | Open | Close |

| IF THE APPLICANT IS **NOT** THE SOLE OWNER THEN THIS APPLICATION AND THE FOLLOWING MUST BE EXECUTED BY THE OWNER OR OWNERS OF THE PHARMACY | Owner Legal Standing<br>☐ Individual<br>☐ Corporation<br>☐ Partnership<br>☐ Unincorporated Association |
|---|---|
| Name of Owner | Owner's Address |

**If Corporation or Unincorporated Association**

| Business Address | Date and Place of Organization |
|---|---|
| | |

# PLEASE ATTACH A COPY OF THE FOLLOWING DOCUMENTS

**(FAILURE TO SUPPLY THESE DOCUMENTS WILL DELAY THE PROCESSING OF YOUR APPLICATION)**

1. A copy of your pharmacy license from the state in which your pharmacy resides

2. A copy of your prescription label

Affix a copy of your prescription label here
(Must Include Toll-Free Telephone Number)

3. Please attach the following as it applies to your business
    a. A list of Owners, Officers or Directors of the Pharmacy with their names and addresses
    -Or-
    b. A list of All Partners, including the applicant if one of the partners with names and addresses

4. A list of all pharmacists with their address and license number

5. A list of all pharmacy interns with their address and license number

6. A copy of your pharmacy's most recent inspection by the State Board of Pharmacy in the state in which your pharmacy resides

7. A copy of your Drug Enforcement Administration (DEA) Registration for your pharmacy

8. A copy of any manufacturing registration that you maintain either with the state in which your pharmacy resides or any federal agency (Food and Drug Administration (FDA), DEA, etc.)

9. A copy of any wholesale/distributor registration that you maintain either with the state in which your pharmacy resides or any federal agency (FDA, DEA, etc.)

10. Please attach any accreditations that you maintain pertaining to your pharmacy, wholesaler/distributor or manufacturing business (i.e. Joint Commission, National Association of Boards of Pharmacy, etc.).

# NON-RESIDENT PHARMACY QUESTIONNAIRE

**(FAILURE TO COMPLETE THIS QUESTIONNAIRE OR SUPPLY SUPPLEMENTAL DOCUMENTS WHEN REQURED WILL DELAY THE PROCESSING OF YOUR APPLICATION)**

Which of the following types of pharmacy practice are you performing? Place an "x" next to each, and you may select multiple types. Please only select the types that you are currently engaged in. If you need to make changes in the future, please contact the Commission of Pharmacy.

| | |
|---|---|
| Community/Mail Order | |
| Infusion/Sterile Compounding | |
| Non-Sterile Compounding | |
| Long Term Care | |
| Nuclear | |

| Questions | Yes | No | N/A |
|---|---|---|---|
| 1. Is the toll-free number available for patients during all business hours? | | | |
| 2. Are any of the owners of the pharmacy a physician? (If yes, please attach a document indicating which individuals are physicians) | | | |
| 3. Has this pharmacy ever received written advisements or warnings, or been disciplined by ANY regulatory agency (State or Federal), or is any action pending? **If the answer to this question is yes, you must submit a copy of such action along with this application.** | | | |
| 4. If your pharmacy is an infusion/sterile compounding pharmacy, do you compound patient specific orders only? | | | |
| 5. If your pharmacy is an infusion/sterile compounding pharmacy, do you compound non-patient specific orders? | | | |
| 6. If you answered yes to question 5, how many days supply is sent to the registrant? | | | |
| 7. If your pharmacy is a non-sterile compounding pharmacy, do you compound patient specific orders only? | | | |
| 8. If your pharmacy is a non-sterile compounding pharmacy, do you compound non-patient specific orders? | | | |
| 9. If you answered yes to question 8, how many days supply is sent to the registrant? | | | |

This is to affirm that the above pharmacy is in compliance 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 agrees to comply with all requests made by the Commission of Pharmacy pursuant to Section 1-2 of Public Act 96-127. I have read the above copy of the requirements of Public Act 96-127 and agree to comply with such requirements.

**I certify, that under penalty of law, the information provided in this application is true to the best of my knowledge.**

| | | |
|---|---|---|
| | | |
| Applicant Signature | Application Name (printed) | Date |