

**DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF PHARMACY
4052 BALD CYPRESS WAY, BIN #C-04
TALLAHASSEE, FLORIDA 32399-3254
(850) 245-4292**



**NON-RESIDENT PHARMACY PERMIT APPLICATION
AND INFORMATION**

DECEMBER 2010



Dear Florida Pharmacy Permit Applicant,

Thank you for applying for a pharmacy permit in the State of Florida. The information in this packet has been designed to provide the essential information required to process your application in a timely manner. Your assistance in providing all required information will enable the Florida Board of Pharmacy (the board) staff to process your application as soon as possible. You are encouraged to apply as early as possible, to avoid delays due to a large volume of applicants.

Florida Statutes require a completed application and fees before your application can be reviewed. Please read these instructions carefully and fully before submitting the application. You should keep a copy of the completed application and all other materials sent to the board office for your records. When you mail the completed application and fees, use the address noted in the instructions and on the application form.

When your application arrives, your fees will be deposited and verified before the staff review can begin. You will receive a letter acknowledging receipt of your application. The staff will notify you within 30 days if any materials are incomplete.

If you need to communicate with the board staff, you are encouraged to email the board staff at mqa_pharmacy@doh.state.fl.us, or you may call us at (850) 245-4292. Phone calls are returned within 24 hours and emails are responded to within 48 hours during normal business hours. Our staff is committed to providing prompt and reliable information to our customers. Many procedures have been streamlined to expedite the processing of applications; we certainly welcome your comments on how our services may be improved.

Sincerely,

The Board of Pharmacy



Non-Resident Pharmacy Permit Application Information

Whether opening a new establishment, changing locations, or changing owners, a pharmacy permit is required prior to operating in the State of Florida. The permit application must be completed and returned to the Florida Board of Pharmacy with the required fee of \$255.00. The application must have the original signatures of the owner or officer of the establishment and the Prescription Department Manager (PDM) or Pharmacist in Charge.

Non-Resident Pharmacy Registration as authorized by Section 465.0156, F.S., is required for those pharmacies located outside the state and which ships, mails, or delivers a dispensed medicinal drug into this state. In order to dispense medicinal drugs into Florida, the pharmacy and the pharmacist designated as the prescription department manager or equivalent must be licensed in the state of location. You must provide a toll free number which is available 6 days a week, not less than 40 hours and the pharmacist is able access the patient records.

Application Processing

Please read all application instructions before completing your application.

- 1) Please mail the application and the \$255.00 application fee (cashiers check or money order made payable to the FLORIDA DEPARTMENT OF HEALTH) to the following address:

Department of Health
Board of Pharmacy
P.O. Box 6320
Tallahassee, Florida 32314-6320

OR, use the following address if you are using express mail:

Department of Health
Board of Pharmacy
4052 Bald Cypress Way, Bin C-04
Tallahassee, FL 32399-3254

- 2) Please submit a letter of licensure verification for the facility as well as for the Pharmacy Manager from the state board of pharmacy where you are located. The letter must include:
 - a. Original Licensure Date;
 - b. Expiration Date; and
 - c. Licensure Status.
- 3) Please submit a copy of your most recent inspection by the state board of pharmacy or the entity responsible for conducting inspections in the state where you are physically located.



Within 30 days of receipt of your application and fees, the board office will notify you of the receipt of your application, any required documents, and your status. If the application is complete, you will be notified that an inspector will contact you to setup an inspection appointment. Please do not contact the board office concerning your inspection date, and allow 30 days for the inspector to contact you. If you have not been contacted by the inspector within 30 days, then notify the board. If your application is incomplete, you will be notified in writing of what is required to make your application complete.

Licensure Process

Once the application is deemed complete, the board staff will issue your license within 15 days. **You may lookup your license number on our website at <http://www.doh.state.fl.us/mqa> under "Lookup Licensee."**



IMPORTANT NOTICE: The department or board shall deny an application for a pharmacy permit if the applicant or an affiliated person, partner, officer, director, or prescription department manager or consultant pharmacist of record of the applicant:

- (a) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, since July 1, 2009.
- (b) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009.
- © Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period.
- (d) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5-year period and the termination occurred at least 20 years before the date of the application.

IMPORTANT NOTICE: The department or board shall deny an application for a pharmacy permit if the applicant or an affiliated person, partner, officer, director, or prescription department manager or consultant pharmacist of record of the applicant has:

- (a) Has obtained a permit by misrepresentation or fraud;
- (b) Has attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation.;
- (c) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy.;
- (d) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any 1285 jurisdiction which relates to health care fraud.;

If applicable to you, please provide the documentation to the Florida Board of Pharmacy.



FLORIDA BOARD OF PHARMACY
 P.O. Box 6320
 Tallahassee, FL 32314-6320
 Telephone (850) 488-0595
<http://www.doh.state.fl.us/mqa/pharmacy>

NON-RESIDENT PHARMACY PERMIT APPLICATION

Application Type – Please choose one of the following:
 ___ New Establishment \$255 fee ___ Additional Permit Type \$255 fee _____ (existing permit number)
 ___ Change of Location \$100 fee _____ (existing permit number)
 ___ Change of Ownership (a new permit number will be issued) \$255 _____ (existing permit number)

Please list your Federal Employer Identification Number: _____

1. Corporate Name		Telephone Number	
2. Doing Business As (d/b/a)		E-Mail Address	
3. Mailing Address			
City	State	Zip	
4. Physical Address			
City	State	Zip	
5. List the Prescription Department Manager			
Name	License No.	Start Date	Signature
6. Contact Person		Telephone Number	
7. DEA Registration Number	8. Do you have 24 hour access to patient records) Yes _____ No _____ (if no explain on separate sheet)		
9. Please provide the name, address, telephone number, and permit number of your prescription drug wholesale distributor. Number			
Name		Telephone Number	Permit Number
Street Address		City	State Zip

10. Operating Hours



<p>Prescription Department Hours</p> <p>Monday-Friday: Open _____ Close: _____</p> <p>Saturday: Open: _____ Close: _____</p> <p>Sunday: Open: _____ Close: _____</p>	<p>Provide the Toll-Free Telephone number available six days a week for 40 hours below:</p> <p>(____) _____ - _____</p>
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11. Ownership Information

a. Type of Ownership: _____ Individual _____ Corporation _____ Partnership
 _____ Other: _____

NOTE: IF CORPORATION OR LIMITED PARTNERSHIP YOU MUST INCLUDE WITH YOUR APPLICATION A COPY OF THE ARTICLES OF INCORPORATION ON FILE WITH THE FLORIDA SECRETARY OF STATE'S OFFICE.

b. Are the applicants, officers, directors, shareholders, members and partners over the age of 18?

Yes _____ No _____

c. List all the owners and officers of the corporation. Each person listed below having an ownership interest of 5 percent or greater and any person who, directly or indirectly, manages, oversees, or controls the operation of the applicant (Attach a separate sheet if necessary)

Owner/Officer-Title	Date of Birth	Mailing Address, City, State, Zip Code	% of Ownership
	/ /		%
	/ /		%
	/ /		%
	/ /		%
	/ /		%
	/ /		%

12. Has anyone listed in 11.c had an ownership interest of 5% or more in a pharmacy or any other business permit which was disciplined, suspended, revoked, or closed involuntarily within the past 5 years?

Yes _____ No _____ If yes, please provide a signed affidavit disclosing the reason the entity was closed.

12a. Has anyone listed in 11.c had an ownership interest of 5% or more in a pharmacy or any other business permit which was voluntarily relinquished or closed voluntarily within the past 5 years?

Yes _____ No _____ If yes, please provide a signed affidavit disclosing the reason the entity was closed.

13. Has anyone listed in 11.c ever obtained a pharmacy permit by misrepresentation or fraud or been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud?

Yes _____ No _____ If yes, please provide documents concerning this conviction.

Pursuant to Section 456.0635(2), *Florida Statutes*, questions 14 through 20 are being asked. If you answer yes to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.

14. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or a similar felony offense in another state or jurisdiction since July 1, 2009? (If yes, provide court documents concerning this conviction)

Yes _____ No _____

15. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication



to a felony under 21 U.S.C. ss.801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009?

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

16. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If no, do not answer 17)

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

17. If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated, has the applicant been reinstated and in good standing with the Florida Medicaid Program for the most recent five years?

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

18. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If no, do not answer 19 and 20)

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

19. Has the applicant been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

20. Did the termination occur at least 20 years prior to the date of this application?

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

21. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant listed on the United States Department of Health Human Services Office of Inspector General's List of Excluded Individuals and Entities?

Yes _____ No _____ (If yes please submit proof)

22. Are you currently registered or permitted in any other states? If yes, provide the state, permit type and permit number for each permit. Attach a separate sheet if necessary.

Yes _____ No _____

State	Permit Type	Permit Number

23. Has the applicant, affiliated person, partner, officer, director ever owned a pharmacy? If yes, provide the name of the pharmacy, the state where the pharmacy is located and the status of the pharmacy. Attach a separate sheet if necessary.

Yes _____ No _____ (If yes, explain on a separate sheet providing accurate details)

Pharmacy Name	State	Status



24. Has any disciplinary action ever been taken against any license, permit or registration issued to the applicant, affiliated person, partner, officer, director, or prescription department manager?

No _____ Yes _____ (If yes, explain on a separate sheet providing accurate details and submit documentation from the licensing agency who took the disciplinary action)

25. Has the applicant, or any officer, member or partner ever been convicted of a felony or misdemeanor, excluding minor traffic convictions?

Yes _____ No _____ (You must include all misdemeanors and felonies, even if adjudication was withheld by the court, so that you would not have a record of conviction. Driving under the influence or driving while impaired is NOT a minor traffic offense for the purposes of this question.)

26. Is there any other permit issued by the Department Health located at the physical location address on this application?

No _____ Yes _____ (If yes, explain on a separate sheet providing accurate details)

27. Does the applicant, affiliated person, partner, officer, director have any outstanding fines, liens or overpayments assessed by a final order of the department? If yes please answer 27d.

No _____ Yes _____ (If yes, explain on a separate sheet providing accurate details)

27d. Does the applicant, affiliated person, partner, officer, director have a repayment plan approved by the department?

No _____ Yes _____ (If yes, explain on a separate sheet providing accurate details)

ALL QUESTIONS MUST BE ANSWERED OR YOUR APPLICATION WILL BE RETURNED

Section 456.013(1), F.S., requires that applicants supplement their applications as needed to reflect any material change in any circumstances or conditions stated in the application, which takes place between the initial filing of the application and the final grant or denial of the license, which might affect the decision of the department.

I certify that the statements contained in this application are true, complete, and correct and I agree that said statements shall form the basis of my application and I do authorize the Florida Board of Pharmacy to make any investigations that they deem appropriate and to secure any additional information concerning me, and I further authorize them to furnish any information they may have or have in the future concerning me to any person, corporation, institution, association, board, or any municipal, county, state, or federal governmental agencies or units, and I understand according to the Florida Board of Pharmacy Statutes that a Pharmacy Permit may be revoked or suspended for presenting any false, fraudulent, or forged statement, certificate, diploma, or other item, in connection with an application for a license or permit, as set forth in Section 465.015(2)(a), F.S.

I hereby attest that these statements are true and correct and recognize that providing false information may result in disciplinary action against my license or criminal penalties pursuant to sections 465.016, 775.082, 775.083, and 775.084, F.S.

SIGNATURE _____ DATE _____
(Owner or officer of establishment)



PHARMACY PERMIT APPLICATION CHECKLIST

Keep a copy of the completed application for your records.

It is recommended that you use the following checklist to help ensure that your application is complete. Failure to attach any required document, or to have required documentation sent to the Board, will result in an incomplete application. Final approval for inspection can not be granted until the application is complete. Faxed applications will not be accepted.

NON-RESIDENT PHARMACY PERMIT

- _____ **Application Completed (all questions answered)**
- _____ **Application signed**
- _____ **Pharmacy Manager Signature**
- _____ **Fee Attached**
- _____ **License Verification for Pharmacy and Pharmacy Manager**
- _____ **Copy of the Articles of Incorporation from the Secretary of State**
- _____ **Bill of Sale is required for Change of Ownership**
- _____ **Recent Inspection Report**