PHARMACY CHANGE OF OWNERSHIP (NON-RESIDENT)
APPLICATION & INSTRUCTIONS

IMPORTANT INFORMATION:

- Submit this application if you are applying to change ownership for a non-resident pharmacy that is currently licensed in Missouri. A different application is required if the pharmacy is changing location, changing names or adding/removing a permit classification. Forms are available online at http://pr.mo.gov/pharmacists-forms.asp.
- **Pharmacy permits are not transferable**. You may not begin operating under the new ownership until a temporary or permanent permit has been issued for the new owners (*see Overview below).*
- Please allow **4-6 weeks** for your application to be processed. Keep a copy of the completed application for your records.
- Questions regarding this application may be sent to pharmacy@pr.mo.gov or (573) 526-6985 (phone) or (573) 526-3464 (fax). Please limit phone calls to the extent necessary.

You can now apply for a license online via the MOPRO licensing portal.
Visit the Board's website at: https://pr.mo.gov/pharmacists-forms.asp if you would like to file an online application in lieu of a paper application.

OVERVIEW OF CHANGE OF OWNERSHIP PROCESS

▶ **STEP 1:**	Submit a completed Missouri Change of Ownership Application and the required $ 360.00 application fee.
▶ **STEP 2:**	Notify the Board office that the change of ownership has been completed. Notification can be made by calling (573) 526—6985 or e-mailing pharmacy@pr.mo.gov. Applicants are responsible for notifying the Board once the change has been completed. **Pharmacy permits are not transferable.**
▶ **STEP 3:**	The Board will issue a temporary pharmacy permit once the office is notified that the change of ownership has been completed. Applicants may begin operating under the new ownership once a temporary permit has been issued. • A temporary permit will not be issued unless a fully completed application form and Prior Owner Affidavit have been returned to the Board office along with the required application fee. • The Board recognizes additional time may be needed to obtain some of the required application documents (i.e.,- home state license verification for the new ownership, new controlled substance registrations). New owners may operate under a temporary permit pending receipt of all final application documents. • Temporary permits expire within six (6) months. Temporary permits will be voided if the application is not completed and all required documents submitted within the required six (6) months. • The temporary permit number will be reflected on the Board's website within twenty-four (24) hours after issuance. On request, a temporary permit number will be provided by the office over the phone or e-mailed. • The prior permit will be deemed null and void and officially terminated in the Board's records once the temporary license is issued.
▶ **STEP 4:**	Complete and return all outstanding application documents *(if any).*
▶ **STEP 5:**	Final application approval and the pharmacy's permanent permit issued. The permanent permit will be mailed to the pharmacy's physical address. Please allow 3-5 days for mailing. *The Board reserves the right to deny or restrict a permanent permit as provided by Missouri law even if a temporary permit has been issued.*

Missouri Non-Resident Pharmacy Change of Ownership Application

APPLICATION CHECKLIST/INSTRUCTIONS

- ☐ **Completed and signed application form**. Incomplete applications will be returned for correction.
- ☐ **Application fee of $360.00** made payable to the Missouri Board of Pharmacy. All fees are deposited upon receipt and are **non-refundable**. A deposited fee does not indicate that the application has been accepted or approved.
- ☐ **Pharmacist-in-Charge Statement:** Must be signed and notarized by the pharmacist-in-charge.
- ☐ **Prior Owner Affidavit**: Must be signed, notarized and returned to the Board before a temporary permit is issued.
- ☐ **Business Entity State Tax Compliance Form**: A "Business Entity State Tax Compliance Form" is included with this application. This application will not be accepted without a Business Entity State Tax Compliance Form.
- ☐ **Certificate of No Tax Due**: Missouri law requires that any business being licensed by the state must provide a Certificate of No Tax Due from the Missouri Department of Revenue if the business engages in retail sales other than prescriptions. Certificates may be obtained at http://dor.mo.gov/business/sales/notaxdue/. Questions about obtaining a Certificate should be addressed to the Missouri Dept. of Revenue at (573) 751-9268. *Note: A Certificate is not required if the Business Entity State Tax Compliance Form is marked to identify that the applicant does not engage in the sale of goods at retail.*
- ☐ **Compounding & Internet Activity Statement:** The statement must be completed and signed by an owner or corporate officer.
- ☐ **Non-Resident Pharmacy License Verification Affidavit**: An official state license verification must be submitted with this application for the new ownership (see sample form attached). Other state verification forms are acceptable if issued by your state regulatory agency. An Online primary source verification from the state's official website is also acceptable in lieu of this form if the verification shows disciplinary history.
- ☐ **Pharmacist License Verification Affidavit**: An official state license verification for the designated pharmacist-in-charge must be submitted with this application (see sample form attached). Other state verification forms are acceptable if issued by your state regulatory agency. An Online primary source verification from the state's official website is also acceptable in lieu of this form if the verification shows disciplinary history.
- ☐ **Copy of state controlled substance registration**. Not required if your state does not issue a separate controlled substance registration or if the applicant will not dispense or distribute controlled substances in Missouri. Check applicable box in Section A of this Application.
- ☐ **Copy of federal controlled substance registration**. Not required if the applicant will not dispense or distribute controlled substances in Missouri. Check applicable box in Section A of this Application.

☐ **Copy of most recent state pharmacy inspection.** For applicants applying for a sterile compounding permit, the inspection must have occurred within the last **eighteen (18) months.** For all other pharmacy applicants, the inspection must have occurred within the last **twenty-four (24) months**. If a state inspection is unavailable, an inspection by the Missouri Board of Pharmacy or from the Verified Pharmacy Program (VPP) operated by the National Association of State Boards of Pharmacy may be submitted. Alternatively, the Board can accept an equivalent third-party inspection by an entity approved by the Board. Contact the Board office for approval of an inspection entity other than a state agency or NABP inspection.

☐ **Subscribe to Board's electronic newsletter/e-alerts**: The Board provides important regulatory news and licensing updates via its electronic newsletter and specially issued e-alerts. Sign up for the Board's newsletter and e-alerts online at http://pr.mo.gov/pharmacists-newsletter.asp.

The applicant should also obtain and submit applications to the following agencies (as applicable):

□ **Missouri Department of Revenue (Taxation)** (573) 751-5860
Div. of Taxation, Office of Registration
P.O. Box 3300, Jefferson City, MO 65102

□ **Bureau of Narcotics and Dangerous Drugs** (State Controlled Substances)** (573) 751-6321
P.O. Box 570, Jefferson City, MO 65102

□ **Drug Enforcement Administration** (Federal Controlled Substances)** (913) 951-4100
7600 College Blvd, Suite 100, Overland Park, KS 66210

OR

Drug Enforcement Administration** (314) 538-4600
317 South 16th Street, Saint Louis, MO 63103 (888) 803-1179

(Requests for DEA Order Forms to purchase Schedule II drugs should be made on the DEA application.)

□ **Provider Enrollment (MO HealthNet)** **https://peu.momed.com**
Missouri Dept. of Social Services e-mail: providerenrollment@dss.mo.gov
P.O. Box 6500, Jefferson City, MO 65102

*** The Missouri Bureau of Narcotics and Dangerous Drugs ("BNDD") and the Drug Enforcement Administration will generally hold the processing of their applications until the Board of Pharmacy has issued a pharmacy permit. The Board office will contact BNDD after a temporary permit has been issued by the Board. Unless other cause exists for delaying or preventing BNDD from issuing a registration, BNDD will issue a Missouri Controlled Substance Registration Number. The pharmacy may contact BNDD to confirm that a number has been issued. At the time the pharmacy is notified that the BNDD registration has been issued, BNDD will notify DEA to approve the federal registration. The federal Certificate of Registration is issued from Washington, D.C.*

MISSOURI PHARMACY PERMIT
CLASS DEFINITIONS

(The Board's rules & statutes are available at http://pr.mo.gov/pharmacists-rules-statutes.asp)

1. **Class A**: *Community/Ambulatory*. A pharmacy that provides services as defined in section 338.010, RSMo, to the general public (including veterinary).
2. **Class B**: *Hospital Pharmacy*. A hospital as defined in section 197.020 or a clinic or facility under common control, management, or ownership of the same hospital or hospital system.
3. **Class C**: *Long-Term Care*. A pharmacy that provides services as defined in section 338.010, RSMo, by the dispensing of drugs and devices to patients residing within long-term care facilities. a long-term care facility means a nursing home, retirement care, mental care or other facility or institution which provides extended health care to resident patients.
4. **Class D**: *Non-Sterile Compounding*. A pharmacy that provides services as defined in section 338.010, RSMo, and provides a non-sterile compounded product as defined in 20 CSR 2220-2.400(1) made from any bulk active ingredient in a batch quantity as defined in 20 CSR 2220-2.400(3).
5. **Class E**: *Radiopharmaceutical*. A pharmacy that is not open to the general public and provides services as defined in section 338.010, RSMo, limited to the preparation and dispensing of radioactive drugs as defined by the food and drug administration (FDA) to health care providers for use in the treatment or diagnosis of disease and that maintains a qualified nuclear pharmacist as the pharmacist-in-charge.
6. **Class F**: *Renal Dialysis*: A pharmacy that is not open to the general public that provides services as defined in section 338.010, RSMo, limited to the dispensing of renal dialysis solutions and other drugs and devices associated with dialysis care.
7. **Class G**: *Medical Gas*. A pharmacy that provides services as defined in section 338.010, RSMo, through the provision of oxygen and other prescription gases for therapeutic uses.
8. **Class H**: *Sterile Product Compounding*. A pharmacy that provides services as defined in section 338.010, RSMo, and provides a sterile pharmaceutical as defined in 20 CSR 2220-2.200(11)(i) and (aa). A Class H permit is not required for pharmacies only providing sterile products within the exemptions outlined in 20 CSR 2220-2.200(25).
9. **Class I**: *Consultant*. A location where any activity defined in section 338.010, RSMo, is conducted, but which does not include the procurement, storage, possession or ownership of any drugs from the location.
10. **Class J**: *Shared Service*. A pharmacy that provides services as defined in section 338.010, RSMo, and is involved in the processing of a request from another pharmacy to fill or refill a prescription drug order, or that performs or assists in the performance of functions associated with the dispensing process, drug utilization review (DUR), claims adjudication, refill authorizations and therapeutic interventions.
11. **Class K**: *Internet*. A pharmacy that provides services as defined in section 338.010, RSMo, and is involved in the receipt, review, preparation, compounding, dispensing or offering for sale any drugs, chemicals, medicines or poisons for any new prescriptions originating from the internet for greater than ninety percent (90%) of the total new prescription volume on any day. A prescription must be provided by a practitioner licensed in the United States authorized by law to prescribe drugs and who has performed a sufficient physical examination and clinical assessment of the patient.
12. **Class L**: *Veterinary*. A pharmacy that dispenses, sells or provides legend drugs for animal use only. Not required if the pharmacy is applying for a Class A permit.
13. **Class M**: *Specialty (Bleeding Disorder)*. A pharmacy that provides services as defined in section 338.010, RSMo, that dispenses blood-clotting products to bleeding disorder patients or that offers or advertises to provide blood-clotting products specifically for bleeding disorder patients, as defined by 20 CSR 2220-6.100.
14. **Class N**: *Automated Dispensing System (Health Care Facility)*. A pharmacy operating an automated dispensing system within a licensed health care facility. An automated dispensing system is defined to include, but is not limited to, a mechanical system that performs operations or activities relative to the storage, packaging or dispensing of medications for patients, and which collect, control, and maintain all transaction information. See also 20 CSR 2220-2.900.
15. **Class O**: *Automated Dispensing System (Ambulatory Care)*. A pharmacy operating an automated dispensing system for ambulatory patients. Not required if the pharmacy is applying for a Class A permit. An automated dispensing system is defined to include, but is not limited to, a mechanical system that performs operations or activities relative to the storage, packaging or dispensing of medications for patients, and which collect, control, and maintain all transaction information. See also 20 CSR 2220-2.900.
16. **Class P:** *Practitioner/Office Clinic*. A pharmacy located in a healthcare practitioner's office or clinic. A pharmacy permit is not required for practitioner office dispensing to his/her own patients. *Final rules not promulgated.*

MISSOURI NON-RESIDENT PHARMACY
CHANGE OF OWNERSHIP APPLICATION

SUBMIT THIS COMPLETED APPLICATION TO:

MAILING ADDRESS
MISSOURI BOARD OF PHARMACY
P.O. BOX 625
JEFFERSON CITY, MO 65102

OVERNIGHT ADDRESS
MISSOURI BOARD OF PHARMACY
3605 MISSOURI BOULEVARD
JEFFERSON CITY, MO 65109

- ✓ SEE INSTRUCTION SHEET FOR COMPLETION OF THIS FORM
- ✓ **$360.00 APPLICATION FEE. FEE IS NON-REFUNDABLE**
- ✓ KEEP COPY OF COMPLETED APPLICATION FOR YOUR RECORDS

FOR OFFICE USE ONLY	
PRE-LICENSE #	INSPECTOR
PERMIT #	
TEMP ISSUE DATE	PERM ISSUE DATE
RECEIVED	

SECTION A: PHARMACY INFORMATION

CURRENT PHARMACY NAME	**CURRENT PHARMACY PERMIT #**

NEW PHARMACY NAME ***(List the new pharmacy dba name after the change of ownership. The pharmacy may only operate under the name and address listed below)***

NEW PHARMACY DBA NAME (If different)

PHARMACY PHYSICAL ADDRESS **(STREET)** **(CITY)** **(STATE)** **(ZIP)**

NEW PHARMACY TELEPHONE #	**NEW PHARMACY FAX #**	**NEW PHARMACY E-MAIL ADDRESS**

PHARMACY FEDERAL EMPLOYER ID NUMBER (FEIN)	**MISSOURI SEC. OF STATE BUSINESS REGISTRATION #** *(If applicable)*

NEW PHARMACY WEBSITE (IF APPLICABLE)

PHARMACIST-IN-CHARGE**:** *Pharmacy operations must be conducted at all times under the supervision of a properly designated pharmacist-in-charge. The attached Pharmacist-in-Charge Statement must be submitted with this application.*

NAME OF DESIGNATED PHARMACIST-IN-CHARGE	**PHARMACIST LICENSE #**	**LICENSE STATE**

DATE OF OWNERSHIP CHANGE

List the proposed date of ownership change. Answer "unknown" if a date has not been identified. You must notify the Board office when the change of ownership officially occurs by calling (573) 526—6985 or e-mailing pharmacy@pr.mo.gov. A temporary permit will be issued once notification of the change is made. The pharmacy may not begin operating under the new ownership until a new temporary or permanent pharmacy permit has been issued for the new owners. ***Pharmacy permits are not transferable.***

PROPOSED DATE OF OWNERSHIP CHANGE	

SECTION B: OWNERSHIP INFORMATION

- *Provide ownership information for the new pharmacy identified in Section A. The owner listed below will be deemed the **official permit holder** of record that is authorized to operate the pharmacy identified in Section A.*
- *The official mailing address listed below will be used for official Board communications, including, legal notices. Note: Renewal notices will be mailed to the pharmacy's physical address.*

OWNER NAME (ENTITY/INDIVIDUAL)

OFFICIAL MAILING ADDRESS **(STREET)** **(CITY)** **(STATE)** **(ZIP)**

TELEPHONE #	**FAX #**	**E-MAIL ADDRESS**

OWNER TYPE:

THE ABOVE OWNER IS A:

☐ Individual/Sole Proprietorship ☐ Corporation ☐ LLC ☐ LP/LLP ☐ Partnership ☐ Government/Tribal Agency

☐ Other _____

List the name of all officers, owners, partners or members for the owner listed above. If the owner is a government or tribal agency, list the names of any agency managers or directors connected with the applicant. Attach a separate sheet if necessary.

NAME	TITLE	ADDRESS	SSN

Provide the following information for any individual, sole proprietor, partner, corporation or other entity owning more than 25% of the applicant. Attach a separate sheet if necessary.

NAME	**ADDRESS**	**SSN (If applicable)**	**% OWNED**

SECTION C: PHARMACY CLASSIFICATION

The new pharmacy is applying for the following permit classes (check ALL that apply):

- ☐ **Class A (Community/Ambulatory)**
- ☐ **Class B (Hospital Pharmacy)**
- ☐ **Class C (Long-Term Care)**
- ☐ **Class D (Non-Sterile Compounding)**
- ☐ **Class E (Radio Pharmaceutical)**
- ☐ **Class F (Renal Dialysis)**
- ☐ **Class G (Medical Gas)**
- ☐ **Class H (Sterile Product Compounding)**
- ☐ **Class I (Consultant Services)**
- ☐ **Class J (Shared Services) **Class J Questionnaire must be completed & attached****
- ☐ **Class K (Internet)**
- ☐ **Class L (Veterinary)**
- ☐ **Class M (Specialty Bleeding Disorder)**
- ☐ **Class N (Automated Dispensing System- Health Care Facility)**
- ☐ **Class O (Automated Dispensing System- Ambulatory Care)**
- ☐ **Class P (Practitioner Office/Clinic)**

SEE INSTRUCTIONS FOR PHARMACY CLASS DEFINITIONS

SECTION D: CHARGES, CONVICTIONS, DISCIPLINARY ACTIONS AND STATUS

Answer all questions in this section. If you answer "yes" to any question, a detailed written explanation must be included with your application (*attach additional sheets if necessary*). Failure to include an explanation or to answer all of the questions will result in your application being rejected. If you are in doubt, answer "yes" and provide an explanation.

- **SUSPENDED IMPOSITION OF SENTENCE/SUSPENDED EXECUTION OF SENTENCE:** You are required to answer "yes" to the criminal history questions and to provide an explanation even if a Suspended Imposition of Sentence ("SIS") or Suspended Execution of Sentence ("SES") has been received. An attorney may advise you that you do not have to report SIS or SES information. However, the Board has access to both SIS and SES records. You must answer "yes" even if you received a SIS or a SES.
- If you answer "yes" to any of the criminal history questions, you must provide court documents that show the dates, charges and dispositions of your arrests/convictions. This typically includes copies of the charging document (complaint, indictment), the Judgment and Sentence and any other documents showing the disposition of your case.
- *338.185, RSMo, provides: "After August 28, 1990, notwithstanding any other provisions of law, the board of pharmacy shall have access to records involving an applicant for a license or permit or renewal of a license or permit as provided within this chapter, where the applicant has been adjudicated and found guilty or entered a plea of guilty or nolo contendere in a prosecution under the laws of any state or of the United States for any offense reasonably related to the qualifications, functions, or duties of any profession licensed or regulated under this chapter, for any offense an essential element of which is fraud, dishonesty or an act of violence or for any offense involving moral turpitude, whether or not sentence is imposed."*

1. Has any owner, partner, officer or the pharmacist-in-charge ever been found guilty or entered a plea of guilty or nolo contendere to a felony or misdemeanor in Missouri or in any other state, country or court (including federal court)? ☐ YES ☐ NO

2. Does any owner, partner, officer or the pharmacist-in-charge currently have any felony or misdemeanor criminal charges pending against them in Missouri or in any other state, country or court (including federal court)? ☐ YES ☐ NO

3. Has any owner, partner, officer or the pharmacist-in-charge ever received a Suspended Imposition of Sentence (SIS) or Suspended Execution of Sentence (SES) (felony or misdemeanor) in any criminal prosecution in Missouri or in any other state, country or court (including federal court)? ☐ YES ☐ NO

4. Has any owner, partner, officer or the pharmacist-in-charge ever been found guilty of or entered a plea of guilty or nolo contendere to any traffic offense resulting from or related to the use of drugs or alcohol in any state, country or court (including a municipal court) whether or not sentence was imposed (SIS) or a suspended execution of sentence (SES) was received? ☐ YES ☐ NO

5. Has any owner, partner, officer or the pharmacist-in-charge ever been, or is now, addicted to any drugs, controlled substances or alcoholic beverages? □ YES □ NO

6. Has any owner, partner, officer or the pharmacist-in-charge ever had an application for a pharmacy technician, pharmacist, pharmacy intern, pharmacy, drug distributor or any other healthcare registration, license, permit, or certificate denied, disciplined or refused in this state, or any other state or country? *(If yes, copies of any denial/refusal/disciplinary documents must be provided)* □ YES □ NO

7. Has any owner, partner, officer or the pharmacist-in-charge ever had any controlled substance registration, license, permit, or certificate denied, disciplined or refused in this state, or any other state or country? *(If yes, copies of any denial/refusal/disciplinary documents must be provided)* □ YES □ NO

8. Has any owner, partner, officer or the pharmacist-in-charge ever been adjudged insane or incompetent by or in any state, country or court? □ YES □ NO

SECTION E: TAX COMPLIANCE

Missouri law requires that the Board verify compliance with designated state sales and withholding tax laws before issuing certain professional licenses or permits that are required to conduct business in this state. Except as otherwise provided below, this application will not be processed unless you provide:

- □ **Business Entity State Tax Compliance Form** (attached to this application)**.**
- □ **A Certificate of No Tax Due** *(required for businesses that engage in retail sales other than prescriptions)***.** Missouri law requires that any business being licensed by the state must provide a Certificate of No Tax Due from the Missouri Department of Revenue if the business engages in retail sales other than prescriptions. Certificates may be obtained online at http://dor.mo.gov/business/sales/notaxdue/. Questions about obtaining a Certificate should be addressed to the Missouri Department of Revenue at (573) 751-9268. *Note: A Certificate is not required if the Business Entity State Tax Compliance Form is marked to identify that the applicant does not engage in the sale of goods at retail.*

Individuals/Sole Proprietors must also complete the following:

PURSUANT TO SECTION 324.010, RSMo:

Were you a Missouri resident in any of the last 3 years? □ YES □ NO

Did you have Missouri income in any of the last 3 years? □ YES □ NO

Were you subject to any Missouri income tax in any of the last 3 years? □ YES □ NO

All tax questions must be completed. False statements are subject to criminal penalties and/or license discipline. Questions regarding income taxes should be sent to the Department of Revenue at (573) 751-7200 or e-mailed to income@dor.mo.gov.

MILITARY BENEFITS/SERVICES

Have you ever served on active duty in the Armed Forces of the United States and separated from such service under conditions other than dishonorable? □ YES □ NO

Would you like to receive information and assistance regarding veterans benefits and services? □ YES □ NO

May the agency share your contact information with the Missouri Veterans Commission to provide such information?

General information may also be found on the Missouri Veterans Commission's website https://mvc.dps.mo.gov/.
□ YES □ NO

SECTION F: APPLICANT AFFIDAVIT

This affidavit must be signed by a partner, corporate officer, or the sole proprietor named in this application. Alternatively, the application may be signed by a person with a designated power of attorney who is authorized to sign and submit this application on the pharmacy's behalf. Proof of the designated power of attorney must be submitted with this application.

This application is hereby submitted on behalf of the pharmacy identified herein. I attest the foregoing application has been completed truthfully and accurately to the best of my knowledge and belief. I am making this affidavit knowing that any false statements or material omission may subject me or the entity identified herein to criminal penalties for making a false affidavit under Section 575.050, RSMo.

I understand that the applicant/pharmacy must comply with all applicable federal and state law(s) as well as the regulations of the Missouri Board of Pharmacy. I attest and understand that the pharmacy shall maintain a pharmacist-in-charge for the facility and such pharmacy shall be conducted and operated in full compliance with state and federal pharmacy, controlled substance and drug distributor laws and regulations. I hereby certify under penalty of perjury that the information and answers contained in this application and any attachments are true and correct to the best of my knowledge and belief.

SIGNATURE OF APPLICANT	**TITLE**
PRINT NAME	**DATE**

SECTION G: APPLICATION CONTACT PERSON

Please provide a contact person for questions from the Board office regarding this license application.

CONTACT NAME			**POSITION/TITLE**	
CONTACT MAILING ADDRESS	**(STREET)**	**(CITY)**	**(STATE)**	**(ZIP)**
CONTACT TELEPHONE #			**CONTACT FAX #**	
CONTACT E-MAIL ADDRESS				

PHARMACIST-IN-CHARGE (PIC) STATEMENT
(MUST BE COMPLETED BY THE DESIGNATED PHARMACIST-IN-CHARGE)

DESIGNATED PHARMACIST-IN-CHARGE NAME	MISSOURI PHARMACIST LICENSE #

PHARMACY NAME

PHARMACY ADDRESS (STREET)	(CITY)	(STATE)	(ZIP)

PHARMACIST-IN-CHARGE E-MAIL ADDRESS	PHARMACIST-IN-CHARGE TELEPHONE #

1. Have you read and do you understand the laws of the State of Missouri relating to pharmacists and pharmacies as embodied in Chapter 195 and 338 Revised Statutes of Missouri? □ YES
2. Do you agree and understand that you are personally responsible for ensuring the pharmacy's compliance with all applicable state and federal law as the pharmacist-in-charge? □ YES
3. Do you agree to observe and abide by all provisions of the above-named Missouri statutes? □ YES
4. Do you agree to observe and abide by all lawful regulations promulgated by the Missouri Board of Pharmacy? □ YES
5. Do you agree to observe and abide by all federal laws and regulations governing storing, dispensing, and sale of legend drugs and pharmaceuticals, including, controlled substances? □ YES
6. Do you understand and agree that no prescription will be compounded, sold or dispensed from your pharmacy except under the direct supervision of a pharmacist currently licensed in the State of Missouri? □ YES
7. Do you understand and agree that no pharmaceutical item bearing the federal "legend" shall be sold, dispensed or otherwise disposed of except by lawful means? □ YES
8. Have you read and do you understand the pharmacist-in-charge requirements as outlined in 20 CSR 2220-2.090? □ YES
9. Do you understand and agree that the pharmacist-in-charge is responsible for the professional and ethical conduct of the pharmacy? □ YES
10. Do you agree that all persons involved in operating the pharmacy will be supervised by a MO licensed pharmacist at all times? □ YES

PHARMACIST-IN-CHARGE ATTESTATION

I _____attest this Statement has been completed truthfully and accurately to the best of my knowledge and belief. I am making this affidavit knowing that any false statements or material omission may subject me or the entity identified herein to criminal penalties for making a false affidavit under Section 575.050, RSMo.

I agree that I will serve as the pharmacist-in-charge of the pharmacy identified in this application. I understand the permit will be issued to the applicant with my name appearing thereon as pharmacist-in-charge. I have reviewed rule 20 CSR 2220-2.090 and agree to comply with the requirements thereof. I understand that I am personally responsible for ensuring the pharmacy's compliance with all applicable state and federal law governing the practice of pharmacy, controlled substances and drug distribution. If my designation as pharmacist-in-charge ends or changes for any reason, I will immediately notify the Missouri Board of Pharmacy. **ALL THIS I AFFIRM UNDER PENALTY OF PERJURY.**

MUST BE SIGNED IN THE PRESENCE OF A NOTARY

SIGNATURE OF PHARMACIST-IN-CHARGE	MISSOURI PHARMACIST LICENSE #
PRINT NAME	DATE SIGNED

NOTARY PUBLIC EMBOSSER OF BLACK INK RUBBER SEAL STAMP	STATE SUBSCRIBED AND SWORN BEFORE ME, THIS _____DAY OF _____ YEAR _____	COUNTY (OR CITY OF ST. LOUIS)

PRIOR OWNER AFFIDAVIT
(THIS SECTION MUST BE COMPLETED BY THE PRIOR OWNERS)

This affidavit must be signed by a partner, corporate officer, or the sole proprietor of the permit holder being purchased, sold or otherwise changing ownership. Alternatively, the application may be signed by a designated power of attorney who is authorized to sign and submit this application on the pharmacy's behalf. Proof of the designated power of attorney must be submitted with this application.

NAME OF INDIVIDUAL SUBMITTING THIS AFFIDAVIT	POSITION/TITLE
NAME OF PHARMACY BEING PURCHASED/CHANGING OWNERSHIP	**PERMIT #**

CONTACT MAILING ADDRESS **(STREET)** **(CITY)** **(STATE)** **(ZIP)**

E-MAIL ADDRESS	PHONE #

CHECK:

☐ I hereby request and understand that the Missouri pharmacy permit number identified herein will be deemed **null and void** after the Board has been notified that the change of ownership is effective.

RECORDS

Complete the following section if the pharmacy records required to be maintained by law (i.e.- prescription records, records regarding the receipt, distribution or other disposition of legend drugs) are **not** being transferred to the new owner. Do not complete if pharmacy records are being transferred to the new owner.

CONTACT PERSON FOR RECORDS QUESTIONS	CONTACT TELEPHONE #

ADDRESS WHERE THE PHARMACY'S PRESCRIPTION RECORDS WILL BE STORED/HELD AFTER THE CHANGE OF OWNERSHIP **(STREET, CITY, STATE, ZIP)**

ATTESTATION

This affidavit must be signed by a partner, corporate officer, or the sole proprietor named in this application. Alternatively, the application may be signed by a person with a designated power of attorney authorizing the individual to sign and submit this application on the pharmacy's behalf. Proof of the designated power of attorney form must be submitted with this application.

I _____ do solemnly swear or affirm that I am a partner, corporate officer or the sole proprietor of the pharmacy identified herein. I hereby request and understand that the Missouri pharmacy permit number identified herein will be deemed **null and void** on the effective date of the ownership change and terminated by the Board. I understand that no pharmacy service identified in section 338.010, RSMo, may be performed by or on behalf of the pharmacy under the current permit number after the permit has been terminated by the Board. All this I affirm under penalty of perjury.

MUST BE SIGNED IN THE PRESENCE OF A NOTARY

SIGNATURE	TITLE
PRINT NAME	DATE SIGNED

NOTARY PUBLIC EMBOSSER OF BLACK INK RUBBER SEAL STAMP	STATE SUBSCRIBED AND SWORN BEFORE ME, THIS _____DAY OF _____ YEAR _____	COUNTY (OR CITY OF ST. LOUIS)

Missouri Division of Professional Registration

MISSOURI BOARD OF PHARMACY

BUSINESS ENTITY STATE TAX COMPLIANCE FORM

Missouri state law requires that businesses engaged in the retail sale of goods must possess a no tax due letter from the Department of Revenue at the time of licensing. Section 114.083.4 RSMo. (Cum Supp 2008) states:

> In addition to the provisions of subsection 2 of this section, beginning January 1, 2009, **the possession of a statement from the department of revenue stating no tax is due under sections 143.191 to 143.265, RSMo, or sections 144.010 to 144.510 shall also be a prerequisite to the issuance or renewal of** any city or county occupation license or **any state license required for conducting any business where goods are sold at retail**. The statement of no tax due shall be dated no longer than ninety days before the date of submission for application or renewal of the city or county license.

You may obtain a tax clearance letter by visiting http://dor.mo.gov/tax/business/sales/notaxdue/index.htm, e-mailing mailto:taxclearance@dor.mo.gov, or calling the Department of Revenue at (573) 751-9268.

Compliance Statement

PLEASE SELECT ONE OF THE FOLLOWING:

□ This business engages in the sale of goods at retail and has filed and paid all of its sales tax obligations. Please provide a copy of your Missouri No Tax Due compliance letter or provide your 8-digit Missouri state tax ID number below.
Missouri state tax number _____

□ This business does not engage in the sale of goods at retail (other than prescriptions).

WARNING: Statements made on this form are subject to audit. A false statement on this form subjects the license to discipline. Any person who makes a false statement on this form, and the business for which the false statement is made, are subject to criminal penalties for misleading a public servant. § 575.060 RSMo.

Name of Entity:_____

Signature: _____ Title: _____
(Owner, President, Partner)

Print Name: _____ Date: _____

MAILING ADDRESS
MISSOURI BOARD OF PHARMACY
P.O. BOX 625
JEFFERSON CITY, MO 65102

OVERNIGHT ADDRESS
MISSOURI BOARD OF PHARMACY
3605 MISSOURI BOULEVARD
JEFFERSON CITY, MO 65109

STATE OF MISSOURI
Division of Professional Registration
Board of Pharmacy
Class J: Shared Services Questionnaire

INSTRUCTIONS

ONLY COMPLETE THIS FORM IF YOU ARE APPLYING FOR OR ADDING A CLASS J: SHARED SERVICES CLASSIFICATION

THIS FORM IS BEING COMPLETED IN CONJUNCTION WITH (SELECT ONE):

- ☐ PHARMACY PERMIT APPLICATION FOR A CLASS J SHARED SERVICES PHARMACY
- ☐ CLASSIFICATION CHANGE APPLICATION

PHARMACY NAME	PERMIT NUMBER (IF APPLICABLE)

ADDRESS (STREET, CITY, STATE, ZIP CODE)

Answer all questions in this section:

1. The pharmacies sharing services are either: (1) under the same ownership or (2) under written contract outlining the services to be provided and the responsibilities and accountabilities of each pharmacy. ☐ YES ☐ NO
2. Each facility sharing services will be licensed by the Missouri Board of Pharmacy and have a Missouri Class J: Shared Services permit. ☐ YES ☐ NO
3. Each pharmacy involved in Class J: Shared Services either: (1) shares a common database or (2) has access to each pharmacy's prescription records and patient profiles and records as needed to safely and properly perform the shared services activities. ☐ YES ☐ NO
4. Each pharmacy sharing services maintains the following:
   - A. Policies and procedures that identify the duties of each pharmacy involved and ensure the safe and appropriate delivery of prescriptions drugs in compliance with 20 CSR 2220-2.013 ☐ YES ☐ NO
   - B. A mechanism for tracking the prescription or medication order during each step of the process. ☐ YES ☐ NO
   - C. Security provisions for protecting the confidentiality and integrity of patient information. ☐ YES ☐ NO
   - D. A designation of the pharmacy responsible for offering patient counseling as required by 20 CSR 2220-2.190 and federal law. ☐ YES ☐ NO
   - E. A quality assurance program that is designed to objectively and systematically monitor and evaluate the quality and appropriateness of pharmacy services and resolve identified problems. ☐ YES ☐ NO
   - F. A list of names, addresses, and Missouri permit numbers for all pharmacies involved. ☐ YES ☐ NO
   - G. For pharmacies not under common ownership, a method to notify patients that his/her prescription or medication order may be filled or compounded by another pharmacy (if applicable). If under common ownership, check here ☐ and go on to Question H. ☐ YES ☐ NO
   - H. Each pharmacy understands compounding may only be performed pursuant to a patient specific prescription/medication order or in anticipation of a patient specific prescription/medication order, as authorized by 20 CSR 2220-2.200 and the rules of the Board. ☐ YES ☐ NO

SIGNATURE	PRINTED NAME
TITLE	DATE

(030122)

MAILING ADDRESS:
MISSOURI BOARD OF PHARMACY
P.O. BOX 625
JEFFERSON CITY, MO 65102
(573) 751-0091
(573) 526-3464 (FAX)

DELIVERY ADDRESS:
3605 MISSOURI BOULEVARD
JEFFERSON CITY, MO 65109

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

PHARMACY SELF-INSPECTION FOR CHANGE OF OWNERSHIP-INITIAL INSPECTION

NAME OF PHARMACY (AS IT APPEARS ON APPLICATION FOR NEW PERMIT)		
STREET	CITY STATE	ZIP CODE
DATE TELEPHONE NUMBER	PHARMACIST-IN-CHARGE NAME	LICENSE NO.

DEFINITIONS FOR SELF-INSPECTION PROCEDURES

The pharmacist-in-charge is required to **complete the self-Inspection process and this form on the day that ownership of the pharmacy is legally transferred or at the beginning of the first day of operation under new ownership.** It is important to ensure compliance in all areas listed on this form before operation under new ownership of a pharmacy can begin. Any false statements made on this form could result in the enforcement of penalties as provided by law.

HAS THIS PHARMACY CHANGED LOCATION?

☐ YES ☐ NO

If this pharmacy has changed location as defined in 20 CSR 2220-2.020(4), the self-inspection process cannot be completed. You must complete and send a change of location application to the board office.

COMPLIANCE

SECURITY OF PHARMACY OPERATIONS

	YES	NO
1) All areas of the physical plant of the pharmacy where drugs received, stored or dispensed and patient records are maintained are inaccessible by the public. (GUIDANCE: It is important that the overall design of the pharmacy does not allow for easy access by the public by Individuals overcoming barriers due to inadequate Installation or use of inadequate construction materials.)	☐	☐
2) In pharmacies where the hours of the pharmacy department differ from the hours of the facility, all means of access to the pharmacy maintain locks and/or alarms to sufficiently deter access by unauthorized personnel.	☐	☐
3) The pharmacy maintains a locked cabinet, fixture or safe in order to store Class II drugs.	☐	☐

REGULATORY REQUIREMENTS

	YES	**NO**
1) An inventory of controlled substances has been completed at the time of the change of ownership. Date completed: _____.	☐	☐
2) The pharmacy maintains current references as required by law.	☐	☐
3) A sink is available with hot and cold running water with an appropriate attachment to a city/county sewer system that is located within or immediately adjacent to the pharmacy and *that* is not considered a part of a restroom facility.	☐	☐
4) Proper refrigeration for the storage of pharmaceutical products is available. Temperature range is maintained between 36º to 46º F.	☐	☐
5) Prescription files are maintained according to laws governing hard copy records and electronic data records. Hard copy records are retrievable on-site as required by law. Sufficient mechanisms exist in order to provide for the numbering of prescriptions that are dispensed.	☐	☐
6) A secure dispensing area is available within the pharmacy physical plant that contains all required equipment for each class of pharmacy noted on the pharmacy permit.	☐	☐

NOTE: Any pharmacy that chooses to store drugs at another address must report such sites as warehouses. Provide the address of any such locations within the space provided on the reverse side.

ATTESTATION:

If you answer no to any of the compliance statements on this form, an inspector will contact you to gather further information or to provide guidance for corrective actions.

As pharmacist-in-charge, I attest that the answers provided on this form are true and correct and that the pharmacy complies with all laws and regulations as they pertain to the operation of a pharmacy. I further attest that I have reviewed and understand all responsibilities as pharmacist-in-charge set forth in 20 CSR 2220-2.090 Pharmacist-In-Charge.

SIGNATURE OF PHARMACIST-IN-CHARGE

NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE		COUNTY {OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS		
	DAY OF	YEAR	**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME [TYPED OR PRINTED)		

OTHER INFORMATION

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P.O. BOX 625
JEFFERSON CITY, MO 65102
(573) 751-0091

DELIVERY ADDRESS:
3605 MISSOURI BOULEVARD
JEFFERSON CITY, MO 65109

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

PHARMACY LICENSE VERIFICATION AFFIDAVIT

APPLICANT

1. Complete items 1-6 only. The remaining portion of the form should be completed by your regulatory licensing agency. An Online primary source verification from the state's official website is acceptable in lieu of this form if the verification shows disciplinary history.
2. Forward the forms to the licensing agency for the state in which you are located. Check with that agency for verification of fee charges.
3. DO NOT RETURN the forms to the Missouri Board of Pharmacy unless they have been completed by the state in which you are located.

   ORIGINALS ARE REQUIRED WITH BOARD SEAL – COPIES WILL NOT BE ACCEPTED

1. PHARMACY DBA NAME	PERMIT NUMBER

2. ADDRESS (STREET, CITY, STATE, ZIP CODE)

3. APPLICANT NAME (CORPORATION, PARTNERSHIP, SOLE PROPRIETOR, LLC, LLP)

4. I HEREBY AUTHORIZE THE_____*(STATE TO WHICH SENDING FORM)* TO FURNISH TO THE MISSOURI BOARD OF PHARMACY THE INFORMATION REQUESTED BELOW.

5. SIGNATURE OF SOLE PROPRIETOR, PARTNER, OR CORPORATE OFFICER OF APPLICANT	6. PRINT NAME

DO NOT WRITE BELOW THIS LINE - FOR LICENSING AGENCY ONLY

LICENSE NUMBER	LICENSE STATUS	DATE LICENSE ISSUED	DATE LICENSE EXPIRES

HAS THIS LICENSE BEEN DISCIPLINED IN ANY WAY?	TYPE OF DISCIPLINE			
☐ YES ☐ NO	☐ REVOKED	☐ SUSPENDED	☐ PROBATION	☐ CENSURE
	☐ LIMITED	☐ RESTRICTED	☐ SURRENDERED	

ATTACH CERTIFIED COPIES OF ALL PERTINENT LEGAL DOCUMENTS

ATTACH COPY OF MOST RECENT INSPECTION REPORT CONDUCTED BY HOME STATE BOARD OF PHARMACY

BOARD SEAL AREA *(AFFIX OFFICIAL STATE SEAL OF LICENSING AGENCY BELOW)*	**RETURN COMPLETED FORM TO:** ***Please return completed form to the applicant for submission with the application.***

SIGNATURE	TITLE	STATE	DATE

MAILING ADDRESS:
MISSOURI BOARD OF PHARMACY
P.O. BOX 625
JEFFERSON CITY, MO 65102
(573) 751-0091

DELIVERY ADDRESS:
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JEFFERSON CITY, MO 65109

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

PHARMACIST LICENSE VERIFICATION AFFIDAVIT

APPLICANT

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2. Forward the forms to the licensing agency for the state in which you are located. Check with that agency for verification of fee charges.
3. DO NOT RETURN the forms to the Missouri Board of Pharmacy unless they have been completed by the state in which you are located.

ORIGINALS ARE REQUIRED WITH BOARD SEAL – COPIES WILL NOT BE ACCEPTED

1. PHARMACIST-IN-CHARGE NAME	LICENSE NUMBER

2. ADDRESS (STREET, CITY, STATE, ZIP CODE)

3. PHARMACY DBA NAME

4. PHARMACY DBA ADDRESS

5. I HEREBY AUTHORIZE THE_____*(STATE TO WHICH SENDING FORM)* TO FURNISH TO THE MISSOURI BOARD OF PHARMACY THE INFORMATION REQUESTED BELOW.

6. SIGNATURE OF SOLE PROPRIETOR, PARTNER, OR CORPORATE OFFICER OF APPLICANT	PRINT NAME

DO NOT WRITE BELOW THIS LINE - FOR LICENSING AGENCY ONLY

LICENSE NUMBER	LICENSE STATUS	DATE LICENSE ISSUED	DATE LICENSE EXPIRES

HAS THIS LICENSE BEEN DISCIPLINED IN ANY WAY?	TYPE OF DISCIPLINE			
☐ YES ☐ NO	☐ REVOKED	☐ SUSPENDED	☐ PROBATION	☐ CENSURE
	☐ LIMITED	☐ RESTRICTED	☐ SURRENDERED	

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SIGNATURE	TITLE	STATE	DATE