

Applicant's Name: \_\_\_\_\_

9902/001	Application	\$ 158
9902/006	Regulatory fee	\$ 10
9902/001	Controlled Substance	\$ 40
9902/	Law Book	\$ 10



STATE OF TENNESSEE  
 DEPARTMENT OF HEALTH  
 BUREAU OF HEALTH LICENSURE AND REGULATION  
 BOARD OF PHARMACY  
 227 FRENCH LANDING, SUITE 300  
 HERITAGE PLACE METRO CENTER  
 NASHVILLE, TENNESSEE 37243  
 PHONE: (615) 741-2718 FAX: (615) 741-2722  
<http://health.state.tn.us/boards/pharmacy/>

## BOARD OF PHARMACY

### APPLICATION FOR PHARMACY BUSINESS

Check appropriate type ownership:

- PROPRIETORSHIP
- PARTNERSHIP
- CORPORATION
- LLC

Please check type of application:

- IN STATE
- OUT OF STATE
- CHARITIBLE CLINIC PHARMACY

**NOTE:** Application CANNOT be processed unless you have a Pharmacist In Charge licensed in Tennessee.

Type of practice:

- COMMUNITY:
- INDEPENDENT-3 or less
  - NON-INDEPENDENT-4 or more
  - HOSPITAL/INSTITUTIONAL
  - NURSING HOME
  - HOME HEALTH CARE
    - MEDICAL GASES
  - NUCLEAR
  - MAIL ORDER
  - OTHER: Explain \_\_\_\_\_

Application status:

- NEW BUSINESS
- LOCATION CHANGE
- NAME CHANGE
- OWNERSHIP CHANGE
- REMODELING

Effective date:

(Must enter date of Opening or Change)

\_\_\_\_\_

\_\_\_\_\_

Name of Pharmacy \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Location Address \_\_\_\_\_ County \_\_\_\_\_

Former Name & Address with Tennessee License Number (if applicable) \_\_\_\_\_

- Name of Owners:
1. Corporation  \_\_\_\_\_
  2. Officers of Corporation  \_\_\_\_\_
  3. Partners  \_\_\_\_\_

Address of Owner(s): \_\_\_\_\_

Street Address

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**PLEASE INCLUDE A COPY OF BOARD OF DIRECTORS OR LIST OF OFFICERS/PARTNERS**

Name and Tennessee License Number of Pharmacists employed, including employer if Pharmacists:

(Name) *attach supporting documents if needed*

(License #)

_____	_____
_____	_____
_____	_____
_____	_____

List reference books, including law book, in this pharmacy: (See Rule 1140-3-.15 or 1140-6-.03)

_____	_____
_____	_____
_____	_____

**Inspection is required before issuance of license.**

**NOTE:** If there is any change in status of this pharmacy, owner and pharmacist are both required to notify the Board.

\*If ownership change, the former owner must complete and sign in space indicated on this form.

**TO BE COMPLETED BY:** (Check one)  **OWNER**                       **OFFICER OF CORP.**                       **ADMINISTRATOR**

*I hereby certify under oath that the pharmacy for which this application is made complies with requirements set forth in Tennessee laws and regulations and that said pharmacy is equipped with proper equipment, adequate lighting, and refrigeration; and that this business will be kept in a clean and sanitary condition at all times.*

Are there any charges involving moral turpitude or violation of pharmacy, or any other laws pending against you? Explain such charges or violations in detail; even to reporting minor infractions of pharmacy, liquor or narcotic laws regulations; include dates.     Yes     No (If yes, please attach)

I do solemnly swear and affirm that I understand the pharmacy laws of Tennessee, and that the information in the foregoing paragraphs are true and correct to the best of my knowledge. Furthermore this pharmacy will be under the direct supervision of a pharmacist at all times. I further attest that this pharmacy will comply with all the provisions of this application.

Signature \_\_\_\_\_

NOTARY PUBLIC: I attest that the above signature (s) of _____	
sworn to and subscribed to before me this _____ day of _____, _____	
My commission expires _____	Notary Signature _____

**TO BE COMPLETED BY PHARMACIST-IN-CHARGE:** (Cannot be executed by a pharmacist who is presently registered as pharmacist-in-charge, except a part-time institutional pharmacist.)

*I, under oath, confirm that in the event the application for a license to conduct a pharmacy at the address stated therein is granted; that I will have supervision over the conduct of such pharmacy; that I will be in actual attendance at the same at least \_\_\_\_\_ hours of each business week; and furthermore, this pharmacy will be under the direct supervision of a pharmacist at all times as established by Tennessee Code Annotated.*

Are there any charges involving moral turpitude or violation of pharmacy, or any other laws pending against you? Explain such charges or violations in detail; even to reporting minor infractions of pharmacy, liquor or narcotic laws regulations; include dates.  Yes  No (if yes attach)

I do solemnly swear and affirm that I understand the pharmacy laws of Tennessee and that the information in the foregoing paragraphs are true and correct to the best of my knowledge. Furthermore this pharmacy will be under the direct supervision of a pharmacist at all times. I further attest that this pharmacy will comply with all the provisions of this application.

Signature \_\_\_\_\_

(check one)  Full-Time  Part-Time

NOTARY PUBLIC: I attest that the above signature (s) of _____ sworn to and subscribed to before me this _____ day of _____, _____ My commission expires _____ Notary Signature _____
--

**TO BE COMPLETED BY FORMER OWNER** (If applicable)

Name and address of former: (Check one)  Owner  Officer of Corporation

*I do solemnly swear/affirm that I understand the pharmacy laws of Tennessee, and that the information contained in this application are true and correct to the best of my knowledge. I relinquish my rights to the name and license of :*

Name of pharmacy: \_\_\_\_\_

Date of ownership change: \_\_\_\_\_

Signature \_\_\_\_\_

NOTARY PUBLIC: I attest that the above signature (s) of _____ sworn to and subscribed to before me this _____ day of _____, _____ My commission expires _____ Notary Signature _____
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