



STATE OF ALASKA  
Department of Commerce, Community, and Economic Development  
Division of Corporations, Business and Professional Licensing  
BOARD OF PHARMACY  
**Physical Address:** 333 Willoughby Avenue, 9<sup>th</sup> Floor, Juneau, Alaska 99801  
**Mailing Address:** P.O. Box 110806, Juneau, Alaska 99811-0806  
**Telephone:** (907) 465-2589 ★ **E-mail:** [license@alaska.gov](mailto:license@alaska.gov)

## PROCEDURE TO OBTAIN A PHARMACY LICENSE

In accordance with AS 08.80.157, a facility engaged in the practice of pharmacy, or a pharmacy where drugs or devices are dispensed, shall be licensed by the board. If operations are conducted at more than one location, each location shall be licensed by the board.

Please read the application, statutes, regulations, and all instructions carefully. It is your responsibility to be aware of licensing requirements and provide all necessary documentation. The board will not issue a license until your application is complete.

### **PHARMACY REGISTRATION REQUIREMENTS:**

1. Completed, notarized application.
2. Fees required in accordance with 12 AAC 02.310; payable to the "State of Alaska."
  - \$ 50.00 Nonrefundable application fee
  - \$300.00 License fee
  - \$350.00 Total required
3. Within 14 days of commencement of business, a completed self-inspection of the premises questionnaire (form on board website) must be submitted to the department.

**Note:** Licenses are nontransferable and any change of name, location, or ownership requires a new license.

**CHANGE OF OWNERSHIP REQUIREMENTS** - In accordance with 12 AAC 52.040, when ownership of a pharmacy changes, a new license is required.

1. Completed, notarized application.
2. Fees required in accordance with 12 AAC 02.310; payable to the "State of Alaska."
  - \$ 50.00 Nonrefundable application fee
  - \$300.00 License fee
  - \$350.00 Total required
3. Within 14 days of commencement of business, a completed self-inspection of the premises questionnaire (form on board website) must be submitted to the department.

**CHANGE OF NAME OR LOCATION REQUIREMENTS** – In accordance with 12 AAC 52.030, the pharmacist-in-charge of a pharmacy that has changed its name or physical address shall apply for a new and separate pharmacy license.

1. Completed, notarized application.
2. Fees required in accordance with 12 AAC 02.310; payable to the "State of Alaska."
  - \$ 50.00 Nonrefundable application fee
  - \$ 5.00 Duplicate License fee
  - \$ 55.00 Total required
3. Within 14 days of commencement of business, a completed self-inspection of the premises questionnaire (form on board website) must be submitted to the department.

### **OTHER INFORMATION**

**PUBLIC INFORMATION** - All information supplied with this application is available to the public unless required to be kept confidential by state or federal law. Information about licensees, including mailing addresses, is available from the division's website at [www.commerce.state.ak.us/occ](http://www.commerce.state.ak.us/occ) under "License Search."

**BOARD WEBSITE** – The current Board of Pharmacy Statutes and Regulations, license applications, facility forms, including the self-inspection forms, board newsletter and other information may be obtained from the board's website: [www.commerce.state.ak.us/occ/ppha.htm](http://www.commerce.state.ak.us/occ/ppha.htm)

"REMOTE PHARMACY" means a facility that provides pharmacy services, including the storage and distribution of prescription drugs, drug regimen review, and patient counseling through a telepharmacy system. Note: A separate application is required for this type of facility. The form may be obtained from the board's website.



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PHARMACY APPLICATION

- Application options: New application (\$350.00), Changes (Change ownership \$350.00, Name change only \$55.00, Location change \$55.00) with existing license numbers.

THIS APPLICATION MUST BE COMPLETED IN FULL. If any section does not apply, please write N/A in the space provided. TYPE OR PRINT IN INK ALL INFORMATION. A personal check, certified check, or money order payable to the "State of Alaska" MUST accompany this application.

Company/Owner Name: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Emergency Telephone Number: \_\_\_\_\_

Federal Employer Identification Number: \_\_\_\_\_

Ownership of Pharmacy:

- Ownership types: Sole Proprietorship, Partnership, Corporation

Name of Owners/Partners/Officers

Title

Blank lines for listing owners/partners/officers and their titles.

Personnel:

Name of Pharmacist-in-Charge: \_\_\_\_\_ License Number: \_\_\_\_\_

Address of Pharmacist-in-Charge: \_\_\_\_\_ Telephone: \_\_\_\_\_

Zip Code: \_\_\_\_\_

List all licensed pharmacists employed:

Name

License Number

Blank lines for listing licensed pharmacists and their license numbers.

**If applicable, list all Remote Pharmacies and locations under control of the Central Pharmacy:**

Remote pharmacies:

Locations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Professional Fitness:**

The following questions must be answered. If any of the following answers are "yes," please explain in detail, on a separate letter, and provide any supporting documents.

- 1. Have you as the owner, or any partner, corporate officer, the pharmacist-in-charge, or any employee violated a federal, state, or local law relating to the practice of pharmacy, drug samples, wholesale or retail drug or device distribution, or distribution of controlled substances? .....  Yes  No
- 2. Have you as the owner, or any partner, corporate officer, the pharmacist-in-charge, or any employee had a felony conviction under federal, state, or local law? .....  Yes  No
- 3. Have you as the owner, or any partner, corporate officer, the pharmacist-in-charge, or any employee furnished false or fraudulent material in an application made in connection with drug or device manufacturing or distribution? .....  Yes  No
- 4. Have you as the owner, or any partner, corporate officer, the pharmacist-in-charge, or any employee had a suspension or revocation by federal, state, or local government of a license currently or previously held for the manufacture or distribution of drugs or devices, including controlled substances? .....  Yes  No
- 5. Have you as the owner, or any partner, corporate officer, the pharmacist-in-charge, or any employee obtained remuneration by fraud, misrepresentation, or deception? .....  Yes  No
- 6. Have you as the owner, or any partner, corporate officer, the pharmacist-in-charge, or any employee had dealings with drugs or devices that are known or should have been known to be stolen drugs or devices? .....  Yes  No

I HEREBY CERTIFY that the information in this application is true and correct. I understand that any false or fraudulent information may result in failure to obtain a pharmacy license in Alaska, or subsequent revocation of license, I understand that information supplied with this application is considered public, unless required to be kept confidential pursuant to state or federal law.

\_\_\_\_\_  
Signature of Owner or Officer

SUBSCRIBED AND SWORN to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

NOTARY SEAL

\_\_\_\_\_  
Notary Public  
My Commission Expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Pharmacist-in-Charge

SUBSCRIBED AND SWORN to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

NOTARY SEAL

\_\_\_\_\_  
Notary Public  
My Commission Expires: \_\_\_\_\_



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## Authorization for Release of Records

To Whom It May Concern:

I, \_\_\_\_\_

as owner or officer of \_\_\_\_\_  
*(name of pharmacy)*

located at \_\_\_\_\_

authorize the Alaska Division of Corporations, Business and Professional Licensing and its investigators to examine records pertaining to litigation, suits, judgments and/or settlements, and any law enforcement records pertaining to the pharmacy and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to the pharmacy to the Alaska Division of Corporations, Business and Professional Licensing and its investigators.

I authorize the Division to discuss the records with persons or organizations which are considered appropriate by the Division in connection with an official investigation, and to provide copies of the records to those persons or organizations deemed appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, drug or alcohol evaluation, diagnosis or treatment received by an owner or officer as it pertains the practice of pharmacy and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis, or treatment.

I request that upon presentation of this release, or a Certified True Copy, that you provide copies of the records to the Division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization is given expressly in connection with our application for licensure as a pharmacy and expires one (1) year from the date of my signature below.

I hereby release you, your organization, the Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing and its investigators, and all others directly or indirectly involved in this matter from any liability or damage which may result from furnishing the information requested.

SIGN HERE



\_\_\_\_\_  
Signature of Owner or Officer

\_\_\_\_\_  
Date

**NOTE:** A photocopy reproduction of this request shall be, for all intents and purposes, as valid as the original. You may retain this form for your files.