



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, 9th Floor, Juneau, Alaska 99801
Mailing Address: P.O. Box 110806, Juneau, Alaska 99811-0806
Telephone: (907) 465-2589 ★ **E-mail:** license@alaska.gov

PROCEDURE TO OBTAIN A DRUG ROOM LICENSE

In accordance with AS 08.80.157, a facility where drugs or devices are dispensed shall be licensed by the board. An institutional facility that does not maintain a pharmacy but prepares and administers prescription drugs from bulk supplies for patients receiving treatment within the facility must be licensed by the board as a drug room.

NOTE: 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.

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 under "License Search."

APPLICATION FOR REGISTRATION

The following must be on file before the board may review the application for approval:

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 |
| <u>\$300.00</u> | License fee |
| \$350.00 | Total required |
3. Names of all owners, partners, or principal corporate officers of the institutional facility.
4. Federal employer identification number.
5. Name of the pharmacist designated to be the pharmacist-in-charge. If the pharmacist-in-charge is employed on a consultant basis, a copy of the written agreement with the consultant pharmacy must be on file.
6. List of pharmacists working in the facility.
7. Completed self-inspection report

APPLICATION FOR CHANGE OF OWNERSHIP

In accordance with 12 AAC 52.040, when ownership of a facility changes, a new license is required. The existing license must be returned and a new application, along with the appropriate fees and supporting documentation, must be submitted. The following must be on file before the board may review the application for approval:

1. Completed application and supporting documentation (see 1 through 7 above).
2. Fees required in accordance with 12 AAC 02.310; payable to the "State of Alaska."

| | |
|-----------------|-------------------------------|
| \$ 50.00 | Nonrefundable application fee |
| <u>\$300.00</u> | License fee |
| \$350.00 | Total required |

APPLICATION FOR CHANGE OF NAME OR LOCATION

In accordance with 12 AAC 52.030, when ownership of a facility changes, a new license is required. The existing license must be returned and a new application, along with the appropriate fees and supporting documentation, must be submitted. The following must be on file before the board may review the application for approval:

1. Completed application and supporting documentation (see 1 through 7 above).
2. Fees required in accordance with 12 AAC 02.310; payable to the "State of Alaska."

| | |
|----------------|-------------------------------|
| \$ 50.00 | Nonrefundable application fee |
| <u>\$ 5.00</u> | Duplicate License fee |
| \$ 55.00 | Total required |



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DRUG ROOM APPLICATION

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

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: _____

Institution Name: _____

Street Address: _____

Zip Code: _____

Mailing Address: _____

Zip Code: _____

Telephone Number: _____ Emergency Telephone Number: _____

Federal Employer Identification Number: _____

Ownership of Institution:

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

Table with 2 columns: Name of Owners/Partners/Officers, Title. Includes checkboxes for Sole Proprietorship, Partnership, and Corporation.

Personnel:

Name of Pharmacist-in-Charge: _____ License Number: _____

Address of Pharmacist-in-Charge: _____ Telephone: _____

Zip Code: _____

List all licensed pharmacists employed:

Table with 2 columns: Name, License Number for listing employed pharmacists.

Professional Fitness:

The following questions must be answered. If any of the following answers are "yes," please explain in detail, in affidavit form, on a separate sheet, 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 drug room 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

Signature of Pharmacist-in-Charge

SUBSCRIBED AND SWORN to before me this _____ day of _____, _____.

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.