APPLICATION INSTRUCTIONS FOR A RESIDENT PHARMACY LICENSE

A new application and fee must be submitted anytime there is:

1) A pharmacy opening; 2) a change in name; 3) a change in ownership; and/or 4) a change in location.

Step #1: Complete the Tennessee Board of Pharmacy Application

- Items to be completed and/or submitted with your application:
  
  1. List of the board of directors, owner(s), partners, or corporate officers
  2. List the Tennessee licensed Pharmacist-in-Charge
  3. List hours of operation
  4. List reference books
  5. Compounding survey

*Be sure that the application is signed and all signatures are notarized.*

- Please include the required fees:

<table>
<thead>
<tr>
<th>Fee</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Registration Fee</td>
<td>$300.00</td>
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<tr>
<td>State Regulatory Fee</td>
<td>$10.00</td>
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<tr>
<td>Controlled Substance Fee</td>
<td>$40.00</td>
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<tr>
<td>Sterile Compounding Fee</td>
<td>$250.00</td>
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If you are not applying for controlled substances qualification, please also submit the Dispenser Exemption or Waiver Request Form found here: https://health.state.tn.us/boards/Controlledsubstance/PDFs/PH-4138.pdf

*All checks and/or money orders should be made out to the Tennessee Board of Pharmacy.*

Step #2: Tennessee Rules

- By submitting an application, you indicate that your facility has met all the requirements necessary for licensure. You may access these rules [1140-01-.08] electronically at http://www.state.tn.us/sos/rules/1140/1140.htm

*It is the Board’s policy that all applications still not approved after one (1) year will expire. If you wish to reapply for Pharmacy licensure, you will be required to submit a new application with registration fee.*
APPLICATION INSTRUCTIONS FOR A NON-RESIDENT PHARMACY LICENSE

A new application and fee must be submitted anytime there is:

1) A pharmacy opening; 2) a change in name; 3) a change in ownership; and/or, 4) a change in location.

Step #1: Complete the Tennessee Board of Pharmacy Application

- Items to be completed and/or submitted with your application:
  1. List of the board of directors, owner(s), partners, or corporate officers
  2. List the Tennessee licensed Pharmacist-in-Charge
  3. List hours of operation
  4. List reference books
  5. A copy of the latest home state inspection
  6. A copy of the home state pharmacy license
  7. A copy of DEA certification (If applicable)
  8. Compounding survey

Be sure that the application is signed and all signatures are notarized.

- Please include application fees:

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If you are not applying for controlled substances qualification, please also submit the Dispenser Exemption or Waiver Request Form found here: https://health.state.tn.us/boards/Controlledsubstance/PDFs/PH-4138.pdf

All checks and/or money orders should be made out to the Tennessee Board of Pharmacy.

Step #2: License a Pharmacist-in-Charge for the practice site

- Rule 1140-01-.08(3)(a)(8) requires that you designate a pharmacist in charge who shall be responsible for compliance with the provisions in this section, and who shall hold a current Tennessee pharmacist license. The Pharmacy practice site application will NOT be approved until the PIC is licensed in Tennessee. Instructions for obtaining a reciprocal license can be found here: https://health.state.tn.us/boards/Pharmacy/PDFs/Obtaining_Reciprocal_License.pdf

Step #3: Tennessee Rules

- By submitting an application, you indicate that your facility has met all the requirements necessary for licensure. You may access these rules [1140-01-.08] electronically at http://www.state.tn.us/sos/rules/1140/1140.htm

It is the Board’s policy that all applications still not approved after one (1) year will expire. If you wish to reapply for Pharmacy licensure, you will be required to submit a new application with registration fee.
APPLICATION FOR PHARMACY BUSINESS

Application status:  Please check type of application:

- NEW BUSINESS  - RESIDENT
- NAME CHANGE   - NON-RESIDENT
- LOCATION CHANGE
- OWNERSHIP CHANGE
- CHARITABLE CLINIC PHARMACY

Effective Date of Opening or Change: ______________

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: _____________________________

Is this a dispensing pharmacy? Yes ☐  No ☐

Does this pharmacy produce or compound sterile or non-sterile products? Yes ☐  No ☐

If yes, please submit a copy of an inspection report issued within the past 12 months.

If no, you are required to immediately report to the board, any changes in the pharmacy business model.

<table>
<thead>
<tr>
<th>Name of Pharmacy</th>
<th>Tennessee License Number (if applicable)</th>
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<tr>
<th>Street Address</th>
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<tr>
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<th>State</th>
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MAILING ADDRESS

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</table>
Check appropriate type ownership:

☐ PROPRIETORSHIP  ☐ PARTNERSHIP  ☐ CORPORATION  ☐ LLC

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

Name of Owners: __________________________________________________________________________________

Address of Owner(s): ____________________________________________________________________________

Street Address

City          State   Zip Code

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

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

(Name) attach supporting documents if needed

__________________________________________________________ ___________________________________________

__________________________________________________________ ___________________________________________

__________________________________________________________ ___________________________________________

__________________________________________________________ ___________________________________________

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

_______________________________________________ ____________________________________________________

_______________________________________________ ____________________________________________________

_______________________________________________ ____________________________________________________

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 ______________________, ______
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 __________________________________________

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 __________________________
Attn: Pharmacist-in-Charge

To ensure compliance with state rules regarding sterile compounding, the Board of Pharmacy voted at the November 2012 meeting to survey Pharmacists-in-Charge about their pharmacy’s compounding practices. Please answer the questions below and return to the board office via fax (615-741-2722) or scan and email to Lakita Taylor at: Lakita.Taylor@tn.gov. The request to complete and return this survey is considered a lawful order of the Board under Tennessee Code Annotated 63-10-305(8). Response is required before a license will be issued.

Name of Pharmacy _________________________________________________________________________________________________

Pharmacy Address____________________________________________________________ Phone Number_______________________

City, State, Zip_____________________________________________________________________________________________________

1. At any time in the past 18 months, has your pharmacy compounded products? _____________
   If yes, is the pharmacy continuing to offer compounding services? ____________
   If a new pharmacy, will your pharmacy compound products? _____________
   (If no, please proceed to the PIC information at the end of the survey and return.)

2. At any time in the past 18 months, has your pharmacy compounded sterile products? ______________
   If yes, is the pharmacy continuing to offer sterile compounding services? ____________
   If a new pharmacy, will your pharmacy compound sterile products? _____________
   (If no, please proceed to the PIC information at the end of the survey and return.)
   (Continue to Question 3.)

3. Approximately how many sterile compounded products does your pharmacy dispense per day?
   a. ___ 1-20 prescriptions per day
   b. ___ 21-50 prescriptions per day
   c. ___ 51-100 prescriptions per day
   d. ___ More than 100 prescriptions per day

4. What types of compounded products does, or will, your pharmacy prepare? (Check all that apply)
   a. ___ IV
   b. ___ Intrathecal
   c. ___ TPN
   d. ___ Parenteral
   e. ___ Cardioplegia solution
   f. ___ Enteral
   g. ___ Irrigation
   h. ___ Ophthamlic
   i. ___ Oncology

continue to next page…
Pharmacy Name__________________________________________________________________________________

j.  ____Veterinary
k.  ____Serum, toxins, vaccines and similar biologics
l.  ____Radiopharmaceuticals
m.  ____Other: ________________________________________________________________________________________

5. List any current accreditation (and expiration date) or pending application for accreditation related to compounding.
________________________________________________________________________________________________________
________________________________________________________________________________________________________

6. If your pharmacy is domiciled outside of Tennessee, does your pharmacy dispense compounded sterile products to Tennessee residents?

7. If located in Tennessee, does your pharmacy dispense compounded product to other states? __________________________
   If yes, to what states do you dispense? __________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________
   _________________________________________________________________________________________________

8. Does your pharmacy have a Policy & Procedure manual addressing compounding? __________________________
   Are you compliant? __________________________

9. If domiciled outside of Tennessee, does your state require USP 797? __________________________

10. Does your pharmacy hold a manufacturer’s license in Tennessee or any other state? ______________________
    If yes, in what states?
    _________________________________________________________________________________________________
    _________________________________________________________________________________________________
    _________________________________________________________________________________________________
    _________________________________________________________________________________________________

11. Have you or your pharmacy’s license ever been disciplined by any licensing agency? _____________
    (If yes, please provide documentation/records of the action taken.)

           I, the undersigned, do hereby swear and affirm that all the answers provided pursuant to this survey are, to the best of my
knowledge, accurate, complete, and true statements. I understand that by knowingly or purposefully making a false, fictitious, or
inaccurate statement, or by making any omission to that effect, that I may be subject to discipline under T.C.A. 63-10-305(6).
Furthermore, I understand that the responses contained herein establish an on-going obligation of accuracy. As such, should any
information on this form change, I will update the Board immediately.

PIC Name_______________________________________  Date___________________________
PIC Signature_____________________________________

Provide the email address where you would like to receive information from the Board in the future.
____________________________________________________________________________________