Nevada State Board of Pharmacy  
985 Damonte Ranch Pkwy Suite 206, Reno, NV 89521  
775-850-1440  
bop.nv.gov

Nevada  
(For locations located in the State of Nevada)  
PHARMACY APPLICATION  
INFORMATION AND CHECKLIST

This application cannot be returned by fax or email.  
We must have an original signature and fee to process.

Failure to submit a complete application will result in significant delays in the processing of the application and issuance of the license.

Please understand we cannot and will not accept incomplete applications. Review the application and return all required fees and documentation with the completed application.

Submission of the application just prior to the deadline date does not guarantee placement on the board agenda.

Please note the application/documentation deadline date is on the board meeting schedule listed on the website. The deadline date is the LAST DAY completed applications will be accepted for that particular board meeting. If the application and all pertaining documentation is not complete and enclosed, the application will be returned.

For a location or name change of an out-of-state pharmacy, we only require notification in writing. A new application is only required if changing ownership of 50% or greater.

REQUIRED DOCUMENTS FOR ALL TYPES OF OWNERSHIP  
You will also be required to submit additional information depending on your ownership type. Details regarding the additional information are included with the application.

- Complete all required pages of the application. Must be original signature(s), no copies or stamps.
- Registration fee of $500.00. This fee is non-refundable and non-transferable. The fee is payable by money order or cashier’s check only, we do not accept personal checks, business checks, cash or credit cards. If the application is received with a personal, business check or cash, it will be returned and will delay the processing of the application. Fee made payable to: Nevada State Board of Pharmacy  
- Statement of Responsibility. This is page 10 included with the application
- Statement of Responsibility - Managing Pharmacist – (2 pages) The managing pharmacist must be registered with the Nevada State Board of Pharmacy and live in Nevada. Pages 11a and 11b.

- Certificate of Corporate status (also referred to as Certificate of Good Standing). The Certificate of Corporate status is obtained from the Secretary of State’s office in the State where incorporated. This Certificate of Corporate status must be dated within the last 6 months.

- Addendum to Pharmacy Application – Internet. This addendum is required if you will be providing internet services. Download the form from the website under the “New Applications” tab. The forms are available under the documents for all types of businesses.

**REQUIRED INFORMATION FOR ALL TYPES OF OWNERSHIP**

An application for Nevada pharmacy requires Board approval. Upon receipt of the completed application, documentation and fee, your application can be placed on the agenda of the next regularly scheduled Board meeting. The current board meeting schedule is available on the website under the “Calendar of Upcoming Boards & Committee Meetings”.

[http://bop.nv.gov/board/ALL/Board_Meeting_Schedule/](http://bop.nv.gov/board/ALL/Board_Meeting_Schedule/)

Appearance(s) at the board meeting may be required. If you have never operated a pharmacy in Nevada before, you will be required to appear at a scheduled board meeting. If an appearance is required, you will be informed by way of confirmation letter two (2) weeks prior to the meeting. Otherwise assume an appearance will not be necessary.

If the application is approved at the scheduled meeting a letter with the information needed to schedule the required pre-opening inspection will be mailed within 15 days from the date of the meeting.

Any change of ownership and/or location change, will require a new application and $500.00 fee. If the address changes, a pre-opening inspection will be required.

Upon board approval and satisfactory inspection a license will be issued and mailed within 15 days from the date of the inspection. A license number will not be provided until the inspection has been completed.

This license is renewed in **October of even numbered years**, no matter when the license is issued. Fees are not pro-rated.

Please access the applicable laws on the website under “Nevada Statues & Regulations” tab.

If you have any questions, contact the licensing specialist in the Reno office at (775) 850-1440 or by email at pharmacy@pharmacy.nv.gov.
APPLICATION FOR NEVADA PHARMACY LICENSE

$500.00 Fee made payable to: Nevada State Board of Pharmacy
(non-refundable and not transferable money order or cashier’s check only)

Application must be printed legibly or typed
Any misrepresentation in the answer to any question on this application is grounds for refusal or denial of the application or subsequent revocation of the license issued and is a violation of the laws of the State of Nevada.

□ New Pharmacy or □ Ownership Change (Provide current license number if making changes: PH_____
Check box below for type of ownership and complete all required forms. **If LLC use Non Public Corporation or Partnership.
□ Publicly Traded Corporation – Pages 1,2,3,10,11a&b □ Partnership - Pages 1,2,6,10,11a&b
□ Non Publicly Traded Corporation – Pages 1,2,4,10,11a&b □ Sole Owner – Pages 1,2,8,10,11a&b

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: _____________________________________________

Physical Address: ____________________________________________

City:_________________________ State: __________ Zip Code: ________ Telephone:____________________

________________________________________ Fax:__________________ Toll Free Number:________

________________________________________ E-mail:_________________

Website: __________________________

Managing Pharmacist: __________________________ License Number: __________

<table>
<thead>
<tr>
<th>TYPE OF PHARMACY AND SERVICES PROVIDED</th>
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<tbody>
<tr>
<td>Yes/No</td>
</tr>
<tr>
<td>□ ☐ Retail</td>
</tr>
<tr>
<td>□ ☐ Hospital (# beds____)</td>
</tr>
<tr>
<td>□ ☐ Internet</td>
</tr>
<tr>
<td>□ ☐ Nuclear</td>
</tr>
<tr>
<td>□ ☐ Ambulatory Surgery Center</td>
</tr>
<tr>
<td>□ ☐ Community</td>
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<tr>
<td>□ ☐ Other: _________________</td>
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</table>

All boxes must be checked
For the application to be complete
APPLICATION FOR NEVADA PHARMACY LICENSE

This page must be submitted for all types of ownership.

Within the last five (5) years:

1) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been charged, or convicted of a felony or gross misdemeanor (including by way of a guilty plea or no contest plea)?
   - [ ] Yes
   - [ ] No

2) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been denied a license, permit or certificate of registration?
   - [ ] Yes
   - [ ] No

3) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been the subject of an administrative action, board citation, site fine or proceeding relating to the pharmaceutical industry?
   - [ ] Yes
   - [ ] No

4) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been found guilty, pled guilty or entered a plea of nolo contendere to any offense federal or state, related to controlled substances?
   - [ ] Yes
   - [ ] No

5) Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever surrendered a license, permit or certificate of registration voluntarily or otherwise (other than upon voluntary close of a facility)?
   - [ ] Yes
   - [ ] No

If the answer to question 1 through 5 is “yes”, a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement, or other disposition may be required.

I hereby certify that the answers given in this application and attached documentation are true and correct. I understand that any infraction of the laws of the State of Nevada regulating the operation of an authorized pharmacy may be grounds for the revocation of this permit.

I have read all questions, answers and statements and know the contents thereof. I hereby certify, under penalty of perjury, that the information furnished on this application are true, accurate and correct. I hereby authorize the Nevada State Board of Pharmacy, its agents, servants and employees, to conduct any investigation(s) of the business, professional, social and moral background, qualification and reputation, as it may deem necessary, proper or desirable.

Original Signature of Person Authorized to Submit Application, no copies or stamps

Print Name of Authorized Person ____________________________ Date ____________________________

Board Use Only

Date Processed: ____________________________ Amount: ____________________________
APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A PUBLICLY TRADED CORPORATION

State of Incorporation: ________________________________

Parent Company if any: ________________________________

Corporation Name: ________________________________

Mailing Address: ________________________________

City:__________________________  State:__________  Zip:__________________________

Telephone:______________________  Fax:______________________

Contact Person: ________________________________

If the corporation that holds an ownership interest in the applicant is a publicly traded corporation, the applicant shall identify the officers of that corporation, the date the corporation received its registration with the SEC, the registration number issued and the exchange at which the stock is being traded. You can provide a copy of the SEC report or copy of Form 10-K.

Date of Incorporation: ________________________________

Registration number issued: ________________________________

Stock Exchange: ________________________________

Hours of Operation for the pharmacy:

Monday thru Friday _____am  _____pm  Saturday _____am  _____pm

Sunday _____am  _____pm  24 Hours _____

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: ________________________________

Include with the application for a publicly traded corporation

Certificate of Corporate Status (also referred to as Certificate of Good Standing). The Certificate is obtained from the Secretary of State’s office in the State where incorporated. The Certificate of Corporate status must be dated within the last 6 months.

List of officers and directors.
APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A NON PUBLICLY TRADED CORPORATION

State of Incorporation: ____________________________________________________________
Parent Company if any: __________________________________________________________
Mailing Address: _________________________________________________________________
City: __________________________ State: ________ Zip: ______________________________
Telephone: ____________________ Fax: __________________________
Contact Person: _________________________________________________________________

For any corporation non publicly traded, disclose the following:

1) List top 4 persons to whom the shares were issued by the corporation?
   a) ___________________________________________________________
      Name __________________________ Business Address ____________________________
   b) ___________________________________________________________
      Name __________________________ Business Address ____________________________
   c) ___________________________________________________________
      Name __________________________ Business Address ____________________________
   d) ___________________________________________________________
      Name __________________________ Business Address ____________________________

2) Provide the number of shares issued by the corporation. __________________________

3) What was the price paid per share? _____________________________________________

List any physician shareholders and percentage of ownership.

Name: ___________________________________________________%:________________
Name: ___________________________________________________%:________________

Hours of Operation for the pharmacy:

Monday thru Friday _____ am ______ pm          Saturday  _____ am ______ pm
           Sunday _____ am ______ pm          24 Hours ______

A Nevada business license is not required, however if the pharmacy has a Nevada business
license please provide the number: ______________________________

Page 4
Include with the application for a non publicly traded corporation continued

Certificate of Corporate Status (also referred to as Certificate of Good Standing). The Certificate is obtained from the Secretary of State's office in the State where incorporated. The Certificate of Corporate status must be dated within the last 6 months.

List of officers and directors

Designated representative form. Download the form from the website under the “Applications/Services” tab. The forms are available under the documents of all types of businesses. Must be an original signature, no copies or stamps.

The designated representative (as defined in NAC 639.5005) needs to complete the form, submit the required 6000 hours of employment with a pharmacy or wholesaler and will be required to take and pass an exam on Nevada law prior to the license being issued. Upon receipt of the completed application, a law book and requirements for taking the exam will be provided to the designee. If the designated representative is the managing pharmacist, the law test is not required.

Complete the personal history record for each stockholder. Download the form from the website under the “Applications/Services” tab. The forms are available under the documents of all types of businesses. Must be an original signature, no copies or stamps.
OWNERSHIP IS A PARTNERSHIP. All persons listed as a partner must accurately complete a personal history record form.

Type of Partnership: General _____ Limited _____

List names of 4 largest partners and percentage of ownership:

Name: ____________________________ %: __________

Name: ____________________________ %: __________

Name: ____________________________ %: __________

Name: ____________________________ %: __________

Partnership Name: ____________________________

Mailing Address: ____________________________

City, State Zip Code: ____________________________

Telephone Number: ____________________________ Fax Number: ____________________________

Contact Person: ____________________________

List any physician shareholders and percentage of ownership.

Name: ____________________________ %: __________

Name: ____________________________ %: __________

Name: ____________________________ %: __________

**Hours of Operation for the pharmacy:**

Monday thru Friday _____ am _____ pm  
Saturday _____ am _____ pm 
Sunday _____ am _____ pm  
24 Hours ____

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: ____________________________
**Include with the application for a partnership continued**

Designated representative form. Download the form from the website under the “Applications/Services” tab. The forms are available under the documents of all types of businesses. Must be an original signature, no copies or stamps.

The designated representative (as defined in NAC 639.5005) needs to complete the form, submit the required 6000 hours of employment with a pharmacy or wholesaler and will be required to take and pass an exam on Nevada law prior to the license being issued. Upon receipt of the completed application, a law book and requirements for taking the exam will be provided to the designee. If the designated representative is the managing pharmacist, the law test is not required.

Complete the personal history record for each stockholder. Download the form from the website under the “Applications/Services” tab. The forms are available under the documents of all types of businesses. Must be an original signature, no copies or stamps.
APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A SOLE OWNER. All information relates to the person listed as the owner.

Owner's Name: ________________________________________________________________

Business Name: ______________________________________________________________

Current Business Address: ______________________________________________________

City: __________________________ State: __________ Zip Code: ______________________

Telephone: ______________________ Fax: ________________________________

List any physician shareholders and percentage of ownership.

Name: __________________________________________ %: _________________________

Name: __________________________________________ %: _________________________

Name: __________________________________________ %: _________________________

Name: __________________________________________ %: _________________________

Hours of Operation for the pharmacy:

Monday thru Friday _____ am _____ pm         Saturday _____ am _____ pm

        Sunday _____ am _____ pm         24 Hours _____

A Nevada business license is not required, however if the pharmacy has a Nevada business license please provide the number: ________________________
Include with the application for a sole owner

Designated representative form. Download the form from the website under the “Applications/Services” tab. The forms are available under the documents of all types of businesses. Must be an original signature, no copies or stamps.

The designated representative (as defined in NAC 639.5005) needs to complete the form, submit the required 6000 hours of employment with a pharmacy or wholesaler and will be required to take and pass an exam on Nevada law prior to the license being issued. Upon receipt of the completed application, a law book and requirements for taking the exam will be provided to the designee. If the designated representative is the managing pharmacist, the law test is not required.

Complete the personal history record. Download the form from the website under the “Applications/Services” tab. The forms are available under the documents of all types of businesses. Must be an original signature, no copies or stamps.
I, ___________________________________________________________
Responsible Person of __________________________________________
hereby acknowledge and understand that in addition to the corporation’s, any owner(s),
shareholder(s) or partner(s) responsibilities, may be responsible for any violations of pharmacy law
that may occur in a pharmacy owned or operated by said corporation.

I further acknowledge and understand that the corporation’s, any owner(s), shareholder(s)
or partner(s) may be named in any action taken by the Nevada State Board of Pharmacy against a
pharmacy owned by or operated by said corporation.

I further acknowledge and understand that the corporation’s, any owner(s), shareholder(s)
or partner(s) cannot require or permit the pharmacist(s) in said pharmacy to violate any provision
of any local, state or federal laws or regulations pertaining to the practice of pharmacy.

____________________________________________________________
Original Signature of Person Authorized to Submit Application, no copies or stamps

_________________________________________    ________________
Print Name of Authorized Person                     Date
Managing Pharmacist

Pharmacist Name: ___________________________  License #: ________

Pharmacy Name: ___________________________

As a managing pharmacist of the above referenced pharmacy, I understand within 48 hours after I report for duty as the managing pharmacist, I shall cause an inventory of all controlled substances of the pharmacy according to the method prescribed by the provision of 21 CFR Part 1304; and cause a copy of the inventory to be on file at the pharmacy.

I understand that as the managing pharmacist I am responsible for compliance by the pharmacy and its personnel with all state and federal laws and regulations relating to the operation of the pharmacy and the practice of pharmacy. I understand my license can be revoked or that I can be the subject of disciplinary action if such laws or regulations are knowingly violated in the pharmacy in which I am managing pharmacist.

I understand that if I cease to be managing pharmacist of the above named pharmacy I will jointly, with the new managing pharmacist, take an inventory of all controlled substances.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Been diagnosed or treated for any mental illness, including alcohol or substance abuse, or physical condition that would impair your ability to perform the essential functions of your license?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>1. been charged, arrested or convicted of a felony or misdemeanor in any state?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. been the subject of a board citation or an administrative action whether completed or pending in any state?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If you marked YES to any of the numbered questions above, please include the following information

<table>
<thead>
<tr>
<th>Board Administrative Action:</th>
<th>State: ______ Date: ___________ Case #: _________</th>
</tr>
</thead>
<tbody>
<tr>
<td>And/or Criminal Action:</td>
<td>State: ______ Date: ___________ Case #: _________</td>
</tr>
<tr>
<td></td>
<td>County: __________________ Court: ____________</td>
</tr>
</tbody>
</table>
1. Insure the pharmacy is operated in accordance with all state and federal laws and regulations. (NRS 639.220)

2. Maintain all outdated, mislabeled or adulterated medications in an isolated area separated from medications for current use. (NRS 639.282, NAC 639.510, NAC 639.473<2>)

3. Notify the Nevada State Board of Pharmacy of all employment changes of pharmacy staff within 10 days of the change. (NAC 639.540)

4. Maintain documentation of pharmacy technician in-service records or technician in training daily logs available for inspection at the pharmacy. (NAC 639.254<2>)

5. A complete controlled substance inventory must be taken every 2 years and whenever there is a pharmacy manager change (must be completed within 48 hours). (CFR 1304.11, NAC 453.475)

6. Report any loss or theft of controlled substances to the Nevada State Board of Pharmacy, Department of Public Safety, and Drug Enforcement Administration within 10 days of the occurrence. (NRS 453.568)

7. Maintain prescription records/logs for 2 years (2 years from last fill date for original paper prescription). NRS 639.236, NAC 453.480)

8. Maintain records of sales to practitioners or other licensed providers as invoices for 2 years. (NRS 639.268, NAC 453.485)

9. Maintain invoice records separated as required for 2 years. (NRS 454.286, NAC 639.487)

I have read all questions, answers and statements and know the content thereof. I hereby certify, under penalty of perjury, that the information furnished on this application is true, accurate and correct.

__________________________________________  ___________________________________
Signature                                         Date