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.

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

Please understand we cannot and will not accept incomplete applications. If there is not an appropriate response, so state with N/A. Review the information and return all required fees and documentation with the completed application.

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 may be accepted for that particular board meeting. If the application and all pertaining documentation is not complete and enclosed, (NO EXCEPTIONS) the application will be returned. Confirmation of personal data may require review.

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.

Statement of Responsibility  This form is page 7 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 8a and 8b.

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
Internet Pharmacy Services Certification. 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

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. If an appearance is required, you will be informed by way of confirmation letter two weeks prior to the meeting. Otherwise assume appearance will not be necessary.

If the application is approved at the scheduled board meeting a letter with the information needed to schedule the required pre-opening inspection will be mailed within 10 days from the date of the last 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 a satisfactory inspection a license will be issued and mailed within 10 days from the date of the pre-opening inspection.

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
- Ownership Change
- Name Change
- Location Change
(Please provide current license number if making changes: PH__________)

- Publicly Traded Corporation - Pages 1,2,3,7,8a,8b
- Partnership - Pages 1,2,5,7,8a,8b
- Non Publicly Traded Corporation - Pages 1,2,4a,4b,7,8a,8b
- Sole Owner - Pages 1,2,6,7,8a,8b

Please check box for type of ownership and complete correct part of the application.

GENERAL INFORMATION to be completed by all types of ownership

Pharmacy Name: ________________________________

Physical Address: ______________________________

Mailing Address: ______________________________________________________

City: _______________________ State: ___________ Zip Code: ________

Telephone: __________________________ Fax: __________________

Toll Free Number: __________________________

E-mail: ______________________________ Website: ______________________

Managing Pharmacist: __________________________ License Number: __________

Hours of Operation:

Monday thru Friday _____am _____pm
Saturday _____am _____pm
Sunday _____am _____pm
24 Hours ____

<table>
<thead>
<tr>
<th>TYPE OF PHARMACY</th>
<th>SERVICES PROVIDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Retail</td>
<td>□ Off-site Cognitive Services</td>
</tr>
<tr>
<td>□ Hospital (# beds _____)</td>
<td>□ Parenteral</td>
</tr>
<tr>
<td>□ Internet</td>
<td>□ Parenteral (outpatient)</td>
</tr>
<tr>
<td>□ Nuclear</td>
<td>□ Outpatient/Discharge</td>
</tr>
<tr>
<td>□ Out of State</td>
<td>□ Mail Service</td>
</tr>
<tr>
<td>□ Ambulatory Surgery Center</td>
<td>□ Long Term Care</td>
</tr>
</tbody>
</table>

Page 1
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 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 questions 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  Received: _______________ 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: ________________________________

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 PUBLICY TRADED CORPORATION

State of Incorporation: __________________________________________________________

Parent Company if any: __________________________________________________________

Corporation Name: ______________________________________________________________

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 __________________________
      Address __________________________________________
   b) __________________________________________ Name __________________________
      Address __________________________________________
   c) __________________________________________ Name __________________________
      Address __________________________________________
   d) __________________________________________ Name __________________________
      Address __________________________________________

NOTE: All persons who are stockholders must accurately complete a personal history record form. Download the form from the website under the ñNew Applicationsò tab. The forms are available under the documents for all types of businesses.

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

3) What was the price paid per share? ____________________________________________

4) What date did the corporation actually receive the cash assets? __________________

5) Provide a copy of the corporation’s stock register evidencing the above information

List any physician shareholders and percentage of ownership.

Name: __________________________________________ %: __________

Name: __________________________________________ %: __________
APPLICATION FOR NEVADA PHARMACY LICENSE

**Include with the application for a non 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

Designated representative form. Download the form from the website under the “New Applications” tab. The forms are available under the documents for all types of businesses.

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 examination on 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 personal history record** for each stockholder. Download the form from the website under the “New Applications” tab. The forms are available under the documents for all types of businesses. Must be original signature(s), no copies or stamp.
APPLICATION FOR NEVADA PHARMACY LICENSE

OWNERSHIP IS A PARTNERSHIP. All persons listed as a partner must accurately complete a personal history record form.

List names of 4 largest partners and percentage of ownership:

Name: ________________________________ %: _________
Name: ________________________________ %: _________
Name: ________________________________ %: _________
Name: ________________________________ %: _________

Partnership Name: ________________________________
Mailing Address: ________________________________
City: __________________ State: ___________ Zip Code: _________
Telephone: __________________ Fax: __________________
Contact Person: ________________________________

List any physician shareholders and percentage of ownership.

Name: ________________________________ %: _________
Name: ________________________________ %: _________

PARTNERSHIP

Include with the application for a partnership

Designated representative form. Download the form from the website under the New Applications tab. The forms are available under the documents for all types of businesses.

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 examination on 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 personal history record for each partner. Download the form from the website under the New Applications tab. The forms are available under the documents for all types of businesses. Must be original signature(s), 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: ___________________________________________%: __________

Are you a registered pharmacist in Nevada? Yes ☐ No ☐ License #: __________

SOLE OWNER

Include with the application for a sole owner

Designated representative form. Download the form from the website under the New Applications tab. The forms are available under the documents for all types of businesses.

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 examination on 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 personal history record. Download the form from the website under the New Applications tab. The forms are available under the documents for all types of businesses. Must be original signature(s), 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 company.

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 or operation of a pharmacy in Nevada.

I further acknowledge and understand that upon the change of managing pharmacist in the pharmacy, the owners must assure that an accountability audit of all controlled substances shall be performed jointly by the departing managing pharmacist and the new managing pharmacist.

Original Signature, no stamps or copies ____________________________ Date ____________________________
Statement of Responsibility

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>
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<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 an administrative action whether completed or pending in any state?</td>
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<td></td>
</tr>
<tr>
<td>3. had your license subjected to any discipline for violation of pharmacy or drug laws in any state?</td>
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<td></td>
</tr>
</tbody>
</table>

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

| Board Administrative Action: | State: _____ Date: ___________ Case #: ________ |
| And/or Criminal Action:     | State: _____ Date: ___________ Case #: ________ |
| County                      | ______________________ Court: __________________

Page 8a
PHARMACY MANAGER’S RESPONSIBILITIES
(PHARMACY MANAGER TO READ, DATE, AND SIGN THIS SECTION)

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.

________________________________________  ______________________________
Original Signature, no stamps or copies                  Date