

**NEVADA STATE BOARD OF PHARMACY**

985 Damonte Ranch Parkway, Suite 206 - Reno, NV 89521 - (775) 850-1440

**Ambulatory Surgical Center (ASC) and Recovery Center (RC) Application**

Rev (09/02/2021)

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

Approval of this application is required to conduct an Ambulatory Surgical Center or a Recovery Center in Nevada. Any change of name, ownership, or location will require a new application and \$500.00 fee. A license to conduct an Ambulatory Surgical Center or a Recovery Center is a revocable privilege, and no holder of such a license acquires any vested right therein or thereunder.

Print and mail the completed application with a **non-refundable fee of \$500.00** paid for by credit or debit card or a check made payable to the **Nevada State Board of Pharmacy**. Credit and debit card payments are charged a **5% processing fee**. Send the completed application to the address indicated on top of this application.

Please ensure all requirements of the application are completed before submission. The deadline date for an application to be considered during a board meeting is posted on our website. If a completed application is not received by our office by the deadline, the application will not be considered until the next scheduled board meeting. **Please note that an application received just prior to the deadline date does not guarantee placement on the board agenda.** For application deadlines and meeting schedule visit [www.bop.nv.gov](http://www.bop.nv.gov).

**Please note:**

- An appearance at a board meeting may be required. If an appearance is required, you will be informed by letter two (2) weeks prior to the meeting.
- Upon approval of the application a pre-opening inspection will be required. Information regarding the pre-opening inspection will be provided to you after the approval of your application.
- Once an application is approved, the facility receives a satisfactory pre-opening inspection and all other requirements of the board have been completed, a license will be issued.
- The license must be renewed in **October of even numbered years** despite when the original license was issued. Fees ARE NOT prorated.
- Nevada statutes and regulations can be accessed at [www.bop.nv.gov](http://www.bop.nv.gov).

If you have any questions, please contact the Nevada State Board of Pharmacy at 775-850-1440 or by email at [pharmacy@pharmacy.nv.gov](mailto:pharmacy@pharmacy.nv.gov).

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**Ambulatory Surgical Center (ASC) and Recovery Center (RC) Application**

**Non-Refundable \$500.00 Fee**

Rev (09/02/2021)

Type of Facility		
<input type="checkbox"/> Ambulatory Surgical Center (ASC) <input type="checkbox"/> Recovery Center (RC)		
Type of Application (check applicable box)		Ownership Type (check applicable box)
<input type="checkbox"/> New ASC/RC <input type="checkbox"/> Ownership Change* <input type="checkbox"/> Location Change * <input type="checkbox"/> Name Change*	* If making a change, provide current license number: _____	<input type="checkbox"/> Publicly Traded (complete sections 1, 2, 3, 7, 8, 9) <input type="checkbox"/> Non-Publicly Traded (complete sections 1, 2, 4, 7, 8, 9) <input type="checkbox"/> Partnership (complete sections 1, 2, 5, 7, 8, 9) <input type="checkbox"/> Sole Owner (complete sections 1, 2, 6, 7, 8, 9)

Section 1: General Information						
ASC/RC Name: _____						
Physical Address: _____						
City: _____		State: _____		Zip: _____		
Mailing Address (if different from physical address): _____						
City: _____		State: _____		Zip: _____		
Telephone: _____			Fax: _____			
Contact Email: _____			Website _____			
Nevada Business License # _____						
Employed/Contracted Pharmacist Name: _____			NV Pharmacist License #: _____			
Medical Director Name: _____						
Days of Operation						
<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday	<input type="checkbox"/> Saturday	<input type="checkbox"/> Sunday

Section 2: History of Company		Yes	No
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)?			
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 from any jurisdiction?			
3. Has the corporation, any owner(s), shareholder(s) or partner(s) with any interest, ever been subject of an administrative action, board citation, cite fine, or proceeding relating to the pharmaceutical industry?			
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?			
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)?			
<b>If you marked YES to any of the number questions (1-5) above, a signed statement of explanation must be attached. Copies of any documents that identify the circumstance or contain an order, agreement or other disposition is required.</b>			

**Section 3: Publicly Traded Corporation**

State of Incorporation: \_\_\_\_\_  
 Parent Company (if any): \_\_\_\_\_  
 Corporation Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Contact Person Name: \_\_\_\_\_

Date of SEC Registration: _____	SEC Registration Number: _____	Stock Exchange Symbol: _____
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Does the number of stockholders/shareholders of the corporation exceed four? NRS 639.231  Yes  No

**Section 4: Non-Publicly Traded Corporation or Company**

State of Incorporation/Organization: \_\_\_\_\_  
 Parent Company (if any): \_\_\_\_\_  
 Corporation/Organization Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Contact Person Name: \_\_\_\_\_

Does the number of members or stockholders/shareholders of the corporation exceed four? NRS 639.231  Yes  No

**Section 5: Partnership**

Partnership Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Contact Person Name: \_\_\_\_\_

Please check type of partnership (NAC 639.214)  General  Limited

Does the number of partners or members of the partnership exceed four? NRS 639.231  Yes  No

**Section 6: Sole Owner**

Owner's Name: \_\_\_\_\_  
 Business Name: \_\_\_\_\_  
 Business Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

**Section 7: Employed/Contracted Pharmacist (MUST BE COMPLETED BY the Employed/Contracted Pharmacist)**

Pharmacist Name: \_\_\_\_\_ NV Pharmacist License #: \_\_\_\_\_

**As the employed/contracted pharmacist, for (ASC/RC Name): \_\_\_\_\_ :**

I understand that I am responsible for establishing policies and procedures which (NAC 639.4996):

- a) Are consistent with the policies and procedures developed pursuant to NAC 639.447;
- b) Require to maintain records in accordance with the provisions of NAC 639.485 and 639.485;
- c) Address the purchase, storage, maintenance of records and dispensing of drugs and investigational drugs;
- d) Require maintenance of a perpetual inventory of all controlled substances;
- e) Prescribe the procedure for quarantining and destroying drugs and investigational drugs that are expired, adulterated, mislabeled or otherwise unsafe for human use;
- f) Require the storage of drugs and investigational drugs in accordance with the specifications of the manufacturer;
- g) Ensure that the ASC and RC dispenses drugs and investigational drugs pursuant to chart orders and in accordance with applicable state and federal laws; and
- h) Ensure that all compounding is
  - a. Performed by a registered pharmacist in accordance with the provisions of NRS and NAC 639; or
  - b. If performed by an employee of the ASC or RC, other than a registered pharmacist, performed:
    - i. In accordance with the provisions of NRS and NAC 639;
    - ii. In a location designated for compounding that is clean and disinfected before each act of compounding; and
    - iii. By a person who has completed training for the type of compounding that will be performed.

I understand that I shall (NAC 639.4998):

- a) Visit the ASC or RC at least once each month to:
  - a. Evaluate the effectiveness of the policies and procedures established pursuant to NAC 639.4996; and
  - b. Confirm that the ASC or RC is complying with those policies and procedures, the below provisions.
- b) Maintain documentation of each visit that the pharmacist makes;
- c) Conduct an audit at least once each month using a sufficient number of records of the ASC or RC, including, without limitation, records of patients and records relating to the purchasing, storing and dispensing of drugs and investigational drugs, which must be randomly selected, to determine whether:
  - a. The records indicate that the drugs and investigational drugs are dispensed in a safe and effective manner in accordance with accepted standards of practice and the specifications of the manufacturer;
  - b. Drugs and investigational drugs are diluted in accordance with accepted standards of practice or pursuant to the specifications of the manufacturer;
  - c. The records demonstrate:
    - i. That a discrepancy does not exist in the number of drugs and investigational drugs that are in vials designated by the manufacturer for a single use which are dispensed and the number of patients who receive such drugs and investigational drugs; and
    - ii. That drugs, not including investigational drugs, which are in vials designated by the manufacturer for a single use and any remaining medication in those vials are discarded after use;
  - d. The records demonstrate that drugs, not including investigational drugs, which are in vials designated by the manufacturer for more than one use are discarded when the medication in the vials has expired or not more than 28 days after the initial breach of the vial;
  - e. The employees of the ASC or RC properly maintain accurate records relating to drugs and investigational drugs; and
  - f. The employees of the ASC or RC properly monitor and maintain the perpetual inventory required pursuant to paragraph (d) of subsection 1 of NAC 639.4996; and
- d) Submit a written report, including, without limitation, a written explanation, to the Board not later than 5 business days after the pharmacist determines that:
  - a. The ASC or RC is violating a state or federal law which affects the care and safety of a patient;
  - b. There is a discrepancy of 5 percent or more between the actual quantity of a controlled substance in the possession of the ASC or RC and the amount of the controlled substance that should be in the possession of the ASC or RC according to the records of the ASC or RC, including, without limitation:
    - i. Purchase orders and invoices for the controlled substance;
    - ii. Records which indicate the removal of the controlled substance from the storage area;
    - iii. Patient records;
    - iv. Records which indicate the return of the controlled substance to the manufacturer;
    - v. Records which indicate that the controlled substance was destroyed; and
    - vi. Any other record for the controlled substance;
  - c. The recovery center or surgical center has intentionally or recklessly failed to create or maintain a record required by the policies and procedures established pursuant to NAC 639.4996;
  - d. The recovery center or surgical center is administering a drug or an investigational drug in violation of accepted standards of practice or the specifications of the manufacturer; or
  - e. The recovery center or surgical center is engaged in a practice which endangers the health, safety or welfare of a patient or employee of the recovery center or surgical center.

Section 8: Personal and Professional History of the Employed/Contracted Pharmacist		Yes	No
1.	Have you 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?		
2.	Have you been charged, arrested, or convicted of a felony or misdemeanor in <u>any</u> state?		
3.	Have you been the subject of a board citation or an administrative action whether completed or pending in <u>any</u> state?		
4.	Has your license been subjected to any discipline for violation of pharmacy or drug laws in <u>any</u> state?		

Please use and make copies of this page (if necessary) to provide information regarding any questions, 1-4, you have marked "YES" to in section 8 of the application. **A signed statement of explanation for each event and a copy of all documents that identify the circumstance or contain an order, agreement or other disposition for the event must be provided.**

**This is in response to Question # \_\_\_\_\_. Provide all the following *where applicable*:**

Date of Event/Arrest	Disposition Date	State	City	County
Case #		Governing, licensing, Arresting Presiding Body/Agency/Court		
Reason/Charge				
Plaintiff/Defendant/Claimant/Respondent			Lawsuit/Arbitration/Bankruptcy	
Name of Business/Industry/Entity				

**Provide explanation below:**

\_\_\_\_\_  
Original signature of Employed/Contracted Pharmacist (copies or stamps not accepted)

\_\_\_\_\_  
Date

Section 9: Provide all the applicable documents with your application based on your Business Type. Required documents are indicated by an "✓" on the right.	Publicly Traded	Non-publicly Traded	Partnership	Sole Owner
• List all Officers and Directors. NRS 639.231(2)(b), NAC 639.214(5)(a)	✓	✓		
• List the top four stockholders and their percent ownership. NRS 639.231(3)	✓	✓		
• List all stockholders who hold 10% or more of the shares. NAC 639.214(4)(b)		✓		
• For General Partnerships, list the name of each partner. NAC 639.214(2) • For Limited Partnerships, list the names of (NAC 639.214(3)): ○ All General Partners; ○ All Limited Partners who hold 10% or more of the interest.			✓	
• Certificate of Corporate Status or Certificate of Good Standing from the Secretary of State's Office where the business is domiciled, dated within the last 6 months.	✓	✓	✓	✓
• Personal History Record Application must be completed by each shareholder/stockholder/partner/member/owner. Form found at <a href="http://bop.nv.gov/Services/newapps/Business/">http://bop.nv.gov/Services/newapps/Business/</a>		✓	✓	✓
• Submit a copy of your license, certification, permit or registration issued to your ASC or RC by the Nevada Division of Public and Behavioral Health of the Department of Health and Human Services.	✓	✓	✓	✓

I certify under penalty of perjury that the information contained in this application is accurate, true and complete in all material respects. I understand that making any false representation in this application is a crime under NRS 639.281. I understand that, pursuant to NRS 239.010, this entire application and any portion thereof is a public record unless otherwise declared confidential by law, and will be considered by the Nevada State Board of Pharmacy at a public meeting pursuant to NRS 241.020. In the event this application is approved I agree to comply with all applicable federal and state statutes and regulations governing this license or registration and understand that any violation may result in discipline.

\_\_\_\_\_  
 Print Name of Authorized Person Submitting Application (If the applicant is a partnership or corporation, the application must be signed by a partner or by an officer of the corporation). NAC 639.215

\_\_\_\_\_  
 Original signature of Authorized Person (copies or stamps not accepted)

\_\_\_\_\_  
 Date

Board Use Only	Date Received: _____	Amount: _____
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# NEVADA STATE BOARD OF PHARMACY

985 Damonte Ranch Pkwy Suite 206, Reno, Nevada 89521

(775) 850-1440 • 1-800-364-2081 • FAX (775) 850-1444

• Web Page: [bop.nv.gov](http://bop.nv.gov)

Applicant Name: \_\_\_\_\_

**Payment:** Pay application fee by providing your credit or debit card information below, or by submitting a check made payable to **Nevada State Board of Pharmacy**.

**Credit Cards are charged a 5% processing fee**

**Credit Type:**

- Visa    MasterCard    Discover  
 American Express

**Credit Card #:**

\_\_\_\_\_

**Expiration Date:**

\_\_ \_\_ / \_\_ \_\_ (MM/YY)

**CVV (3 digits on back of card):**

\_\_\_\_\_

**License Amount:**

\$ \_\_\_\_\_

**Name on Card:**

\_\_\_\_\_

**Billing Address:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_