Virginia Department of Health Professions
Board of Pharmacy

9960 Mayland Drive, Suite 300
Henrico, Virginia 23233
(804) 367-4456 (Tel)
(804) 527-4472 (Fax)
pharmbd@dhp.virginia.gov
www.dhp.virginia.gov/pharmacy

APPLICATION FOR A PHARMACY PERMIT
INSTRUCTIONS PAGE

Application fees are not refundable.
Applications are valid for one year from the date of receipt.
The required fees must accompany the application. Make check or money order payable to "Treasurer of Virginia".
Send ORIGINAL application to the Board for processing.
Mail application, payment, and all additional documentation to the address above.

The information below details the sections of the applications required to be filled out in their entirety. One application may be used for multiple requests.

New Pharmacy Permit –Sections A, B, C, E and F
Change of Ownership –Sections A, D, E and F
Change of Pharmacy Name ONLY–Section A
Change of Pharmacist-In-Charge –Section A and B
Change of Location –Section A and C
Remodel of Prescription Department –Section A and C
Reinstatement – Section A, B and C

ADDITIONAL DOCUMENTATION:

- If this is an application for a ***new pharmacy permit***, please attach a detailed description of your business model including the types of medications to be dispensed, patients served and if any function of prescription processing is to be done at another location.
- If this is a ***change of location, new pharmacy permit request, or remode***l due to physical/structural changes to an existing approved prescription department, PLEASE ATTACH a diagram or footprint of the proposed new or remodeled pharmacy department.
- If the ***remodel*** request is for changes to the previously approved alarm system, PLEASE ATTACH a description of the changes that occurred.
- Please attach any other pages with additional documentation as described in the sections below.

Do not include instruction page when submitting application.

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Check appropriate box(es) and see instructions on last page.

☐ New	$500.00	☐ Change of Pharmacist-In-Charge	$65.00
☐ Change of Ownership	$65.00	☐ Change of Location	$300.00
☐ Change of Pharmacy Name	No Fee	☐ Remodel of Prescription Dept.	$300.00
☐ Reinstatement	Call Board for Fee		

If reinstatement, due to: ☐ Lapse of Permit or ☐ Suspension or Revocation of a Permit

Please check the appropriate box(es) to describe the practice:

☐ Chain Community (5+locations same owner)	☐ Long Term Care	☐ Student Health
☐ Independent Community	☐ Home Health/Infusion	☐ Free Standing ED
☐ Hospital	☐ Nuclear	☐ Outsourcing Facility
☐ FQHC, Health Dept, Free Clinic, CSB	☐ Mail Order Only	
☐ Opioid Treatment Program	☐ Veterinary Only	

SECTION A – ALL APPLICANTS

Name of Pharmacy – If change of pharmacy name, provide the new legal name		
Street Address – If change of location, provide the proposed new physical address		
City	State	Zip Code
Telephone Number	Fax Number	Federal Employment Identification Number (FEIN)
If a current pharmacy permit is held, indicate permit number **0201-**	Email address for Pharmacy correspondence	
(Print) Name of the Pharmacist-In-Charge (PIC) - if change of PIC, list incoming	Pharmacist License Number of the PIC **0202-**	
Signature of PIC – if change of PIC, incoming PIC signature		

By affixing my signature, I acknowledge that I have read and understood Guidance Document 110-27 and associated information regarding the inspection process. Furthermore, I attest that I am in full and actual charge of the pharmacy and am fully engaged in the practice of pharmacy at the location designated on this application.

OFFICE USE ONLY	Date:	Applicant Number:	Receipt Number:

SECTION B – NEW PHARMACY PERMITS & CHANGE OF PIC

Effective Date of Change (date assuming role as PIC)	E-mail address for PIC

Has the pharmacist obtained a minimum of two years of experience practicing as a pharmacist in Virginia or another U.S. jurisdiction? If yes, please provide the information below (attach separate sheet if needed): Yes ☐ No ☐

Pharmacy name:	Pharmacy address:	Date range of practice:
Pharmacy name:	**Pharmacy address:**	**Date range of practice:**

SECTION C – INSPECTION

Contact information to schedule inspection	Expected Opening, Moving, or Remodel Completion Date	Requested Inspection Date

A 14-day notice is required for scheduling an inspection. Drugs may not be stocked prior to inspection and approval. An inspector will call prior to the requested date to confirm readiness for inspection. If the inspector does not call to confirm the date, the responsible party should call the Enforcement Division at 804-367-4691 to verify the inspection date with the inspector.

SECTION D – CHANGE OF OWNERSHIP

Previous Name of Legal Owner
Effective Date of Change of Ownership

SECTION E – NEW PHARMACY PERMIT & CHANGE OF OWNERSHIP

List of Pharmacists practicing at this pharmacy other than the PIC or attach a separate sheet if needed.

Name: _____ License No. **0202-** _____

Name: _____ License No. **0202-** _____

Name: _____ License No. **0202-** _____

Expected Hours of Operation:

OWNERSHIP TYPE—check one: Corporation ☐ Partnership ☐ Individual ☐ Other ☐

Name of ownership entity if different from name of application:

Street Address:		Phone No.
City:	State:	Zip Code:

State(s) of incorporation:

List all other trade or business names used by this facility – Attach separate sheet if needed.
Name: _____
Name: _____

Please list any partner or partners, and, if a corporation, then the corporate officers and directors - Attach separate sheet if needed.	
Name: _____	Title: _____
Mailing Address: _____	
Name: _____	Title: _____
Mailing Address: _____	

SECTION F - QUESTIONS

Please answer the following questions:	
1. Does the pharmacy engage in the compounding of **STERILE** drug products?	Yes ☐ No ☐
2. Does the pharmacy engage in the compounding of **NON-STERILE** drug products?	Yes ☐ No ☐
3. Does the pharmacy share or intend to share the same physical space with an outsourcing facility? If yes, all compounding must be performed in compliance with cGMPs and the facility must also obtain a permit as an outsourcing facility.	Yes ☐ No ☐