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

Check Appropriate Box(es):

☐ New[3, 4]	$500.00	☐ Change of Pharmacist-In-Charge[2, 4]	$65.00
☐ Change of Ownership[2]	$65.00	☐ Change of Location[3]	$300.00
☐ Change of Pharmacy Name[2]	No Fee	☐ Remodeling of Prescription Dept.[3]	$300.00
☐ Reinstatement[1, possibly 3]	Call Board		

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

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 payable to "Treasurer of Virginia". Send ORIGINAL application to the Board for processing.

Name of Pharmacy		Area Code and Telephone Number	
Street Address		Area Code and Fax Number	
City		State	Zip Code
If a current pharmacy permit is held, indicate the permit number **0201-**	Telephone Number (currently working number)	Federal Employment Identification Number (FEIN)	
(Print) Name of the Pharmacist-In-Charge (PIC) (if change of PIC, list incoming)		License Number of the PIC **0202-**	
Signature of PIC – if change of PIC, incoming signature		[2] Effective Date of Change (if change of PIC, date assuming role as PIC)	
By affixing my signature I acknowledge that I have read and understood Guidance Document 110-27 and associated information regarding the inspection process.		Expected Hours of Operation:	

[4] 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:

E-mail address for Pharmacist-In-Charge	[3] Expected Opening, Moving, or Completion Date	[3] Requested Inspection Date

[3] **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.

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

Name: _____ **Name:** _____

Name: _____ **Name:** _____

LIST OF OWNERS/OFFICERS AND RESIDENCE ADDRESSES, OR LIST IS ATTACHED ☐

Name: _____ Title: _____

Residence Address: _____

Name: _____ Title: _____

Residence Address: _____

LIST OF PHARMACISTS PRACTICING AT THIS PHARMACY OTHER THAN PIC OR LIST IS ATTACHED ☐

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

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

Please answer the following questions:

1. Does the pharmacy engage in the compounding of **HIGH RISK STERILE** drug products?	Yes ☐ No ☐
2. Does the pharmacy engage in the compounding of **MEDIUM RISK STERILE** drug products?	Yes ☐ No ☐
3. Does the pharmacy engage in the compounding of **LOW RISK STERILE** drug products?	Yes ☐ No ☐
4. Does the pharmacy engage in the compounding of **NON-STERILE** drug products?	Yes ☐ No ☐
5. 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 ☐

FOR OFFICE USE ONLY:

Date processed:	Check No:	Receipt No:	Application No:

Permit Number: **0201-**	Date sent to Enforcement:	Date sent to PMP:	Reviewed by:	Date Issued: