

STATE OF NEBRASKA
DEPARTMENT OF HEALTH & HUMAN SERVICES
Division of Public Health
Licensure Unit
P. O. Box 94986
Lincoln, NE 68509-4986

APPLICATION TO AMEND A LICENSE TO OPERATE A PHARMACY

- ✓ **FOR ALL 3 AMENDMENT SITUATIONS:** Submit (1) an ORIGINAL **amendment form** AND (2) the ORIGINAL **pharmacy license**.
- ✓ **FOR PIC AMENDMENTS:** In addition to (1) the ORIGINAL **amendment form** and (2) the ORIGINAL **pharmacy license**, submit (3) a completed ORIGINAL **affidavit for PIC on pharmacy technician approval** AND (4) a COPY of the **controlled substance inventory** taken AT THE TIME OF PIC CHANGE. **There is NO GRACE PERIOD for the pharmacy to be without a PIC.** The required materials for change of PIC must be submitted to the Department within 30 days after the actual PIC change.
- ✓ Keep a copy of the information you send to the Department.
- ✓ There is not a fee to amend a license. Location and change of ownership cannot be amended on an existing license. Both require the issuance of a new license.

SECTION A – PHARMACY FACILITY INFORMATION:

PHARMACY INSPECTOR'S NAME: _____

PHARMACY NAME: _____ LICENSE NUMBER: _____

PHARMACY ADDRESS: _____
(Street/P.O. Box/Route)

(City) (State) (Zip) (Phone Number)

NAME OF OWNER(S), PARTNERS OR CORPORATION: _____

IF CORPORATION, NAME OF CORPORATE OFFICERS: _____

OWNER ADDRESS: _____
(Street/P.O. Box/Route)

(City) (State) (Zip)

SECTION B - REASON FOR AMENDING PHARMACY LICENSE:

_____ 1. **CHANGE OF PHARMACIST-IN-CHARGE**
(Must be filed within 30 days of change of PIC)

Effective Date of change: _____

Previous pharmacist in charge _____ Lic # _____

New pharmacist in charge _____ Lic # _____

NOTE: A copy of a controlled substances inventory taken pursuant to a change in the pharmacist-in-charge must be forwarded to the Department within 30 days after completion.

_____ 2. **CONTINUATION OF PHARMACY LICENSE BY HEIRS OR ESTATE OF DECEASED LICENSEE**
(Must be filed within 30 days of death)

Effective Date of change: _____

Name of deceased licensee: _____

Date of death: _____

Name of heirs/estate: _____

Name of pharmacist in charge: _____ Lic.# _____

_____ 3. **NAME CHANGE:**
(Licensee must notify the Department within 5 working days when there is a change in the name of the pharmacy)

Effective Date of change: _____

Current Name: _____

New Name: _____

SECTION C - AFFIDAVIT

I do solemnly swear and affirm that I am the person authorized to sign this application to amend a pharmacy license and that all the statements made are true and complete in all respects.

(Legal Signature of Authorized Person)

(Printed Name and Title)

(Date)