



Division of Public Health
Licensure Unit
 P.O. Box 94986
 Lincoln, NE 68509-4986

ACCOUNTING Business Unit 25550346

**APPLICATION FOR LICENSE TO OPERATE A
 LONG-TERM CARE AUTOMATED PHARMACY**

Application Fee: \$625.00 (Make check payable to DHHS Licensure Unit)

SECTION A—LONG-TERM CARE AUTOMATED PHARMACY LICENSE INFORMATION

Name of Long-Term Care Automated Pharmacy:			
Address of Long-Term Care Automated Pharmacy:	Street:		
	City:	State:	Zip:
Name of owner(s) or Corporation or LLC of Long-Term Care Automated Pharmacy:		If Corporation or LLC, name and titles of officers or members:	
Pharmacist-In-Charge:	Name:	License Number:	
Anticipated Date of Dispensing:			

SECTION B — PROVIDER PHARMACY INFORMATION

Name of Provider Pharmacy:		License Number of Provider Pharmacy:	
Address of Provider Pharmacy:	Street:		
	City:	State:	Zip:
Telephone Number:		Fax Number:	
Email Address:			
Please supply a contact person if we have questions:	Name:		
	Phone:	Email:	

SECTION C — CONTROLLED SUBSTANCES REGISTRATION

Are controlled substances going to be dispensed? *If so, a Federal Controlled Substances Registration is required. Please submit a copy of the registration to the Department immediately after you have received it from the DEA.*

YES NO

SECTION D — AFFIDAVIT

I hereby state that I am the person making application, I am of good character, and the statements on this application are true and complete.

The application must be signed and dated by (place a check mark in the appropriate box below):

- The owner or owners if the applicant is a sole proprietorship, a partnership, or a limited liability company that has only one member;
- Two of its members if the applicant is a limited liability company that has more than one member;
- Two of its officers if the applicant is a corporation;
- The head of the governmental unit having jurisdiction over the business if the applicant is a governmental unit; or
- If the applicant is not an entity described above, the owner or owners or, if there is no owner, the chief executive officer or comparable official.

(Printed Name & Title of Applicant)

(Signature & Title of Applicant)

(Date)

(Printed Name & Title of Applicant)

(Signature & Title of Applicant)

(Date)

Please Note: All supporting documentation required to complete your application must be submitted within **150 days** from the date your application is received by the Department. If such documentation is not submitted within this time, your application and supporting documentation will be destroyed and a refund will be processed, less the administrative fee of \$25.00.