NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

REINSTATEMENT FOR MS

ACCOUNTING
Business Unit #25550346

Division of Public Health
Licensure Unit
PO Box 94986
Lincoln NE 68509-4986
(402) 471-2118

Fee: $625.00

APPLICATION FOR MAIL SERVICE PHARMACY REINSTATEMENT PERMIT

1.	Name of Pharmacy (***name as listed on home state license***):			
	Physical Address of Pharmacy:	Street/PO/Route:		
		City:	State:	Zip:
	Mailing Address of Pharmacy:	Street/PO/Route:		
		City:	State:	Zip:
	Pharmacy Phone Number:		Pharmacy Fax Number:	
	Pharmacy Permit Number: *This permit must be issued by the state from which drugs are being mailed, shipped or delivered in any manner.*		From State of: Expiration Date of Pharmacy Permit:	
	Name of Owner(s), Partners, or Corporation: *May attach separate sheet, if necessary.*		If Corporation, Name of Corporate Officers: *May attach separate sheet, if necessary.*	
2.	Pharmacy's Licensing Contact Name and Title:		Pharmacy's Licensing Contact Number:	
3.	Name of Pharmacist in Charge: *As listed on the facility's state pharmacy license.*			
	License Number of Pharmacist: *This license must be issued by the state from which drugs are being mailed, shipped or delivered in any manner.*		From State of: Expiration Date of Pharmacist License:	
4.	This pharmacy currently employs a Nebraska licensed pharmacist on a full-time basis when Nebraska prescriptions are being processed for mailing, shipping, or delivering in any manner. The PIC does **NOT** need to be the one designated as the Nebraska licensed pharmacist.			
	Name of Nebraska Licensed Pharmacist:		NE License #:	
	I, _____, understand and agree that I am responsible for ensuring compliance by (Name of NE licensed Pharmacist) _____ with the Nebraska Mail Service Pharmacy Licensure Act. (Name of Pharmacy) _____ Signature of the Nebraska Licensed Pharmacist			
5	Please list the names of **ALL** pharmacists who work in this pharmacy and their license numbers in your state with expiration date (may attach separate sheet).			
	Name		License Number	Expiration Date

6.	Please answer the following questions regarding the requirements for obtaining and maintaining a pharmacy permit in the state in which your pharmacy is located. **(Please explain any "No" answers at the end of the section or on a separate sheet.)**			
	a.	Is a pharmacist-in-charge or other designation of a licensed pharmacist who is responsible for activities in the pharmacy required for issuance of a pharmacy permit?	☐YES	☐NO
	b.	Is a pharmacy inspection required for issuance of a pharmacy permit?	☐YES	☐NO
	c.	Is a pharmacy required to have environmental controls to properly store pharmacy products?	☐YES	☐NO
	d.	Is a pharmacy required to be maintained in a clean, orderly and sanitary manner at all times?	☐YES	☐NO
	e.	Are pharmacy reference materials required for issuance of a pharmacy permit?	☐YES	☐NO
	f.	Is a pharmacy required to have controlled access to the prescription department with a lockable prescription drug inventory for issuance of a pharmacy permit?	☐YES	☐NO
	g.	Are written control procedures and guidelines for pharmacy technicians required to be approved by the Board for a pharmacy to use pharmacy technicians?	☐YES	☐NO
	h.	What is the acceptable ratio of pharmacy technicians to licensed pharmacists?		
	i.	What functions and tasks may be performed by pharmacy technicians? (may attach separate sheet)		
	j.	Please explain any "No" answers from the above questions here or on a separate sheet:		
7.	Please answer the following questions regarding the requirements for obtaining and maintaining a pharmacist license in the state in which your pharmacy is currently located:			
	a.	What is the educational requirement for licensure as a pharmacist?		
	b.	What are the continuing education requirements for renewal of a pharmacist license?		

8.	a.	Has the pharmacy facility's license in any state or territory been denied, limited, restricted, revoked, suspended or disciplined in any manner? (If you answer YES, submit a letter of explanation addressed to the Nebraska Board of Pharmacy and submit documentation of the action taken against the license.)	☐ YES ☐ NO
	b.	Has the facility's Pharmacist-in-Charge license in any state or territory been denied, limited, restricted, revoked, suspended or disciplined in any manner? (If you answer YES, submit a letter of explanation addressed to the Nebraska Board of Pharmacy and submit documentation of the action taken against the license.)	☐ YES ☐ NO
	c.	Has the facility's designated Nebraska licensed pharmacist's license in any state or territory been denied, limited, restricted, revoked, suspended or disciplined in any manner? (If you answer YES, submit a letter of explanation addressed to the Nebraska Board of Pharmacy and submit documentation of the action taken against the license.)	☐ YES ☐ NO

9. ATTESTATION AND DESIGNATION OF THE NEBRASKA SECRETARY OF STATE AS AGENT FOR SERVICE OF PROCESS.

I hereby attest to the following **(CHECK ALL THAT APPLY)**:

☐ The applicant pharmacy and pharmacist-in-charge **have not** been in violation of the statutes related to the practice of pharmacy in the State of _____;

☐ The applicant pharmacy and pharmacist-in-charge **have not** been in violation of the statutes related to the practice of pharmacy in the State of Nebraska;

☐ The applicant pharmacy and/or the pharmacist-in-charge have been in violation of the statutes related to the practice of pharmacy in the State of _____. A letter of explanation addressed to the Nebraska Board of Pharmacy and documentation of the action taken against the license(s) have been submitted with this application.

☐ The applicant pharmacy and/or the pharmacist-in-charge have been in violation of the statutes related to the practice of pharmacy in the State of Nebraska. A letter of explanation addressed to the Nebraska Board of Pharmacy and documentation of the action taken against the license(s) have been submitted with this application.

I hereby attest that the Nebraska Secretary of State is designated as my Agent for Service of Process in all matters regarding the Mail Service Prescription Drug Act.

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.

If the applicant is a sole proprietorship for the purpose of complying with Neb. Rev. Stat. §4-108 through 4-114, the applicant must attest as follows (place a check mark in the appropriate box below):

☐ I am a citizen of the United States

☐ I am a qualified alien under the Federal Immigration and Nationality Act.
My immigration and alien number are as follows: _____ and **I agree to provide a copy of my USCIS**.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

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)