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

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

ACCOUNTING
Business Unit 25550346

APPLICATION FOR LICENSE TO OPERATE AN IN-STATE PHARMACY

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

The Department will issue a **Provisional Pharmacy License** after review and approval of your application by a pharmacy inspector up to FIVE WEEKS prior to the anticipated opening date as listed on this application. Due to the statutory requirements in place regarding the timing of the inspection, it is **IMPERATIVE** that you list an accurate opening date and notify the Department AS SOON AS POSSIBLE if your anticipated opening date changes. A Provisional License is good for one year from the date of issuance and is not renewable. The Pharmacy Inspector will conduct an Initial Onsite Inspection within 60 days of issuance of the Provisional License.

A **permanent license** will be issued after successful passage of the Initial Onsite Inspection. You may contact the DEA at www.deadiversion.usdoj.gov or 888-803-1179 to apply for a Federal Controlled Substances Registration. (If this is a change of location, you are not required to obtain a new DEA number; however, the DEA will need to be advised of the change in license number.)

SECTION A—LICENSE INFORMATION			
Name of Pharmacy:			
Physical Address:	Street/PO/Route:		
	City:	State:	Zip:
Telephone Number:		Fax Number:	
E-mail Address:			
Is this a change of ownership? ☐ YES ☐ NO	If YES, Name and license number of existing pharmacy:		
Is this a change of location? ☐ YES ☐ NO	If YES, Name, address, and license number of the pharmacy that is relocating?		
Anticipated Opening Date:			
Please supply a contact person if we have questions:	Name:		
	Phone:	E-mail:	
Name of Owner(s), Partners, LLC or Corporation:			
If Corporation or LLC, Name of Corporate Officers or members:			
Address of Owner(s):	Street/PO/Route:		
	City:	State:	Zip:
Days/Hours Pharmacy Open for Business:			
PIC Information:	Name:	License #:	Expiration date:

SECTION B — CONTROLLED SUBSTANCES REGISTRATION	
Are controlled substances to be dispensed? *If so, a Federal Controlled Substances Registration is required.* ☐ YES ☐ NO	
You may apply for a federal controlled substances registration on-line at www.deadiversion.usdoj.gov	
SECTION C — STANDARDS FOR THE OPERATION OF A PHARMACY	
Please type or print clearly a **detailed** description of how your pharmacy will meet the following requirements in compliance with 175 NAC 8, Sections 8-006 and 8-007. If you need additional room, you may attach a separate sheet)	
1.	How will the prescription inventory and prescription records of the pharmacy be secured when there is no pharmacist/dispensing practitioner on the premises? (see 8-006.02C)
2.	How will your pharmacy ensure that drugs, devices, and biologicals are kept at the proper temperature? (see 8-006.02A)
3.	How will your pharmacy ensure that none of its saleable inventory contains any drug, device, or biological which is misbranded or adulterated? (see 8-006.02D)

SECTION C — STANDARDS FOR THE OPERATION OF A PHARMACY (continued)	
4.	What services will your pharmacy be providing? (Examples of services which may be provided by a pharmacy include, but are not limited to: ambulatory dispensing, unit-dose dispensing, sterile compounding, non-sterile compounding, and administration of vaccinations or injections.)
5.	What facilities, utilities, and equipment will you be providing at your pharmacy? (see 8-007 and 8-006.02) (Facilities include such items as counters, drawers, shelves, etc. Utilities include such items as lights, heat/air conditioning, electricity, hot/cold running water. Equipment includes such items as mortar and pestle, IV hood, balance, etc.)
6.	What specific reference materials will be provided to the pharmacist/dispensing practitioner in your pharmacy? (Please indicate if these are printed or electronic form) (see 8-007.03)

SECTION D — AFFIDAVIT

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.

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.

Revised 5/2018