

**APPLICATION FOR A DRUG DISPENSING PERMIT  
LOCATED IN A PUBLIC HEALTH CLINIC**

**SECTION A: APPLICATION FEE - \$125.00**

Name of Public Health Clinic: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street/PO Box/Route)

\_\_\_\_\_  
(City) (State) (Zip Code)

Telephone/Cell Number: \_\_\_\_\_  
(Area Code)

E-mail Address: \_\_\_\_\_

Name Of Owner(S), Partners or Corporation:

\_\_\_\_\_  
\_\_\_\_\_

If corporation, name of corporate officers:

\_\_\_\_\_  
\_\_\_\_\_

Address Of Owner:

\_\_\_\_\_  
(Street/PO Box/Route)

\_\_\_\_\_  
(City) (State) (Zip Code)

Telephone/Cell Number: \_\_\_\_\_

Anticipated Opening Date: \_\_\_\_\_

Days and Hours of Dispensing: \_\_\_\_\_

**Name of Consultant Pharmacist:** \_\_\_\_\_

**Nebraska Pharmacist License #:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

**SECTION B: AFFIDAVIT** (This section must be notarized)

STATE OF \_\_\_\_\_)

COUNTY OF \_\_\_\_\_)

I, \_\_\_\_\_, being first duly sworn, say that I am the person making application for a Drug Dispensing Permit and that the statements herein are true and complete.

\_\_\_\_\_  
Signature of Authorized Agent for Public Health Clinic

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Address

Sworn to and signed before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

(SEAL)

\_\_\_\_\_  
NOTARY PUBLIC

My Commission Expires: \_\_\_\_\_