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 LONG-TERM CARE AUTOMATED DISPENSING PHARMACY LICENSE

✓**FOR PIC AMENDMENTS**:   In addition to (1) the ORIGINAL **amendment form** and (2) the ORIGINAL **pharmacy license**, submit *AND* (3) 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 – LICENSE INFORMATION:

PHARMACY INSPECTOR'S NAME: _____

LTC AUTOMATED DISPENSING 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. **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)