

Return Application
 With Check Payable To:
NH Board of Pharmacy
 Annual Licensing Fee:
\$150

State of New Hampshire
Board of Pharmacy
 57 Regional Drive
 Concord, NH 03301-8518
 Tel.: (603) 271-2350 Fax: (603) 271-2856
 Website: www.nh.gov/pharmacy

Board Use Only (Do Not Write In This Box)

Check #: _____

July 1, 2011 – June 30, 2012
Registration Period

LIMITED RETAIL DRUG DISTRIBUTOR
PUBLIC HEALTH CLINIC

(UNDER CONTRACT WITH THE DIVISION OF PUBLIC HEALTH SERVICES)

Clinic Name & Address: (Actual Licensed Location)					
Clinic Name _____					
Street Address _____					
City _____		State _____		Zip Code _____	
Telephone: _____		Fax: _____		E-Mail Address (If Applicable): _____	
Parent Company (If Applicable): _____					
Clinic Specialty: <input type="checkbox"/> Family Planning <input type="checkbox"/> STD <input type="checkbox"/> Other Please Specify: _____			Security: Alarm Installed: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Applicant's Proposed Drug Activity: (To bona fide patients of clinic only) <input type="checkbox"/> Administer (Non-Controlled Drugs) <input type="checkbox"/> Dispense (Non-Controlled Drugs) <i>Licensure does not authorize the receipt, storage or dispensing of controlled substances.</i>					
Name Of Owner(s): (Indicate Individual, Partners, Etc. - If Corporation, Show Title Of Officers) Attach Additional Sheet If Necessary					
Name _____		Address _____		Title _____	
Name _____		Address _____		Title _____	
Has registration or licensure granted to the applicant by any state or federal agency ever been suspended or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "yes", attach a detailed description).					
Provide the information below for the person responsible for the operation of the clinic: (The permit & future renewals will be directed to this person)					
Name: _____		Title: _____		Tel. #: _____	
Business Mailing Address: _____					
Hours of Operation					
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Provide name(s) of person(s) in charge of drug purchasing, dispensing records and security. (Use Reverse Side If Necessary)					
Medical Director:					
Name _____		Address _____		Telephone Number _____	

ALL QUESTIONS MUST BE ANSWERED – INCOMPLETE APPLICATIONS OR APPLICATIONS WITHOUT BOTH THE CONSULTANT PHARMACIST'S & THE CLINIC REPRESENTATIVE'S SIGNATURES WILL NOT BE ACCEPTED.

APPLICATION CONTINUED ON OTHER SIDE ↴

Practitioners: (Use Reverse Side If Necessary)			
Name:	Title:	Name:	Title:

Consultant Pharmacist:		
Name	Signature (Applications without consultant's signature will be returned)	NH License No.

Declaration And Signature By Clinic Representative:
<p>I declare under penalties of perjury that this application (including any accompanying documents) has been examined by me and to the best of my knowledge and belief is a true, correct and complete application, and if the permit herein applied for is granted, I hereby agree to and do submit to the jurisdiction of the New Hampshire Board of Pharmacy and to the laws and rules of this State.</p>
<p>Signature: _____ Title: _____ Date: _____ <i>(Responsible Party)</i> <i>(Indicate whether owner, partner, or officer of corporation)</i></p>
<p>* THE LICENSEE SHALL NOTIFY THE BOARD, IN WRITING, OF ANY CHANGES IN THE INFORMATION CONTAINED IN THIS APPLICATION.</p>