PCY-01, Rev 9/09

STATE OF CONNECTICUT
DEPARTMENT OF CONSUMER PROTECTION
DRUG CONTROL DIVISION
COMMISSION OF PHARMACY
Telephone: (860) 713-6070
Website: www.ct.gov/dcp

For Official Use Only

APPLICATION FOR PHARMACY LICENSE
** CONNECTICUT/IN-STATE PHARMACIES ONLY **

INSTRUCTIONS:

All spaces must be completed - please print in ink or type. This application **must be accompanied by a check or money order for the appropriate fee as listed below**, made payable to: "*Treasurer, State of Connecticut*". **Application fees are non-refundable.** This application must be filed at least fifteen (15) days in advance:

1. of the time when it is desired to have such license go into effect if application is for a change of ownership, change of manager, change of name and/or change of officers/directors.
2. of the next regularly scheduled Commission of Pharmacy meeting if application is for a new pharmacy license and/or change of location.

➔ Return your completed application and fee to:
Department of Consumer Protection, License Services, 165 Capitol Avenue, Hartford, CT 06106

Applying For:
- ☐ **New Pharmacy License ($750.00 fee)**
- ☐ **Change of Ownership ($90.00 fee)**
- ☐ **Change of Manager ($90.00 fee)**
- ☐ **Change of Location ($190.00 fee)**
- ☐ **Change of Name ($90.00 fee)**
- ☐ **Change of Officers/Directors ($60.00 fee)**

***NOTE*: If you are applying for a "New Pharmacy License",** your pharmacy must, in accordance with Connecticut Regulations, Section 20-576-54, be classified in one or more of the classes below, based upon the type of pharmacy/business practice in which your pharmacy is involved. You may operate in one or more classes with no increase in the license fee you pay. In making your selection, you should consider that the class or classes you choose should reflect, in a substantial manner, the type of business or professional practice in which your pharmacy is involved.

☐ **Community** ☐ **Infusion Therapy** ☐ **Long-term Care** ☐ **Nuclear** ☐ **Specialty**

Pharmacy Information:

Name of Pharmacy			
Street Address	**City or Town**	**State**	**Zip Code**
Telephone Number (w/ Area Code)	**FEIN Number**	**If Change, Current Pharmacy License Number**	
New Pharmacist Manager (Name & Address)		**New Pharmacist Manager** (License Number)	

Ownership Information:

Owner Legal Standing: ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company	
Name of Owner	Owner's Address (Street, City, State & Zip)
If applicant is NOT the sole owner, has the owner or owners appointed applicant as manager of the pharmacy with complete power over the pharmaceutical affairs of said pharmacy? ☐ Yes ☐ No	

If Corporation or Unincorporated Association:

Business Address of above corporation or association (Street, City, State & Zip)	Date and Place of Legal Organization

List Names of Officers, Directors:

Name (First,Last)	Address (Street, City, State & Zip)
Name (First,Last)	Address (Street, City, State & Zip)
Name (First,Last)	Address (Street, City, State & Zip)

If this is an application for a new pharmacy,a change of ownership, manager or officers has the applicant, any partner or member of the board of directors ever been convicted of a felony crime? ☐ YES ☐ NO If yes - please attach a statement including the date(s) of the conviction(s), the court(s) where the case(s) were decided and a description of the circumstances involved.

If Individual or Partnership:

List names of all partners [include applicant if one of the partners]. If more than three partners, attach rider setting out all names.

Name (First,Last)	Address (Street, City, State & Zip)
Name (First,Last)	Address (Street, City, State & Zip)
Name (First,Last)	Address (Street, City, State & Zip)

If this application involves a change in Pharmacy Name, Manager, Location or Ownership - please provide the information requested in the appropriate box (es) below:

PREVIOUS: Name of Pharmacy & Pharmacy License Number	PREVIOUS: Name of Pharmacist Manager and License Number
PREVIOUS: Location (Street, City, State & Zip)	PREVIOUS: Name of Owner(s)

Name and license number of each pharmacist employed at this location:

Name (First,Last)	License Number
Name (First,Last)	License Number
Name (First,Last)	License Number

Store Hours of Operation:

Daily - Weekdays _____ a.m. _____ p.m. **Saturday & Sunday** _____ a.m. _____ p.m.

Prescription Department Opening and Closing Hours (if different and pre-approved by Pharmacy Commission)

Daily - Weekdays _____ a.m. _____ p.m. **Saturday & Sunday** _____ a.m. _____ p.m.

Please list additional information concerning hours of operation below:

I hereby appoint _____ to have complete control and management

(Name of Pharmacist Manager/Applicant)

over this pharmacy's premise. _____

Signature - Owner or Authorized Officer

State the approximate time the pharmacy will be ready for inspection _____

_____

Applicant Signature (Pharmacist Manager)

_____ | _____

Signature Owner / Owners Signature Owners(s)

** Note: If the owner is a partnership, all partners must sign this application. If the owner is a corporation, this application must be signed by a duly authorized official of said corporation*

AFFIX PRESCRIPTION LABEL OR REASONABLE FACSIMILE OF LABEL HERE *(New Applicants & Change of Location Only)*

TO BE FILLED BY THE TOWN, CITY, OR BOROUGH CLERK, ZONING BOARD OR OTHER PROPER AUTHORITY. (NEW APPLICANTS AND CHANGE OF LOCATIONS ONLY)

This is to certify that I am acquainted with the zoning ordinances and by-laws of the town / city listed below and that the location of this Pharmacy is not prohibited by either the ordinances or by-laws of said town / city at the location described on this application.

_____ _____

Name of Town / City / Borough Signature - Zoning Authority

_____ _____

Town / City / Borough Clerk Date