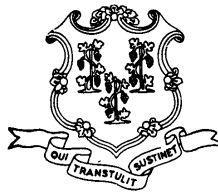


**STATE OF CONNECTICUT**  
**DEPARTMENT OF CONSUMER PROTECTION**  
**DRUG CONTROL DIVISION**  
**COMMISSION OF PHARMACY**  
 Email: [dcp.pharmacylicense@ct.gov](mailto:dcp.pharmacylicense@ct.gov)  
 Website: [www.ct.gov/dcp](http://www.ct.gov/dcp)



For Official Use Only
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## APPLICATION FOR A CHANGE OF LOCATION FOR AN OUT- OF- STATE PHARMACY

**INSTRUCTIONS:**

1. All spaces on this form must be completed.
2. This application must be accompanied by a check or money order in the amount of **\$190.00** made payable to "Treasurer, State of Connecticut." Application fees are non-refundable.
3. Attach a copy of the updated prescription label that you intend to use.
4. If applicable, complete all the appropriate change forms as needed based on the changes to your business.
5. Mail this completed application, fee and required attachments to:  
 Department of Consumer Protection, License Services Division, 450 Columbus Blvd, Ste. 801, Harford, CT 06103

**Pharmacy Information**

Pharmacy Name		CT Pharmacy Registration #	
Current Address	City	State	Zip Code

**New Location Information**

New Location Address	City	State	Zip Code
Telephone Number	Email Address to be used for all correspondence		

**Pharmacy Hours:**

Monday – Friday: Open: \_\_\_\_\_ Close: \_\_\_\_\_  
 Saturday: Open: \_\_\_\_\_ Close: \_\_\_\_\_  
 Sunday: Open: \_\_\_\_\_ Close : \_\_\_\_\_

**Store Hours:**

Monday – Friday: Open: \_\_\_\_\_ Close: \_\_\_\_\_  
 Saturday: Open: \_\_\_\_\_ Close: \_\_\_\_\_  
 Sunday: Open: \_\_\_\_\_ Close: \_\_\_\_\_

**Certification**

By signing this form, I certify the new location is in compliance with zoning ordinances and by-laws of the city/town and that the information contained in this application is the truth to the best of my knowledge and have attached all of the documents required that are applicable to this registration.

Printed Name of New Pharmacy Manager	
Signature of New Pharmacy Manager	Date