



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

**STATE OF DELAWARE**  
**BOARD OF PHARMACY**

TELEPHONE: (302) 744-4500  
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## APPLICATION FOR IN-STATE PHARMACY PERMIT INSTRUCTION SHEET

### When to File Application

This is the application for licensure of a Retail or Hospital Pharmacy located in Delaware – that is, In-State Pharmacy.

- A Pharmacy–Hospital license is for the in-house pharmacy that dispenses to hospital in-patients.
- A Pharmacy–Retail license is for any of these types of outlets:
  - Community Pharmacy – A retail pharmacy that dispenses directly to patients and is not a nuclear or specialty institutional pharmacy.
  - Nuclear Pharmacy – A pharmacy that provides radiopharmaceutical services or an appropriate area set aside in institutional facility (Section 13.2 of the Board's [Rules and Regulations](#)).
  - Specialty Institutional Pharmacy – Institutional pharmacies which provide specialized pharmacy services not generally obtainable from other pharmacies. Examples are short term or primary care treatment facilities that have onsite pharmacies on site such as outpatient chemotherapy centers, primary treatment centers, free standing emergency rooms, rapid in/out surgical centers and certain county health programs (Section 20.0 of the Board's [Rules and Regulations](#)).

File this application when applying for an initial license for any of the above types of in-state pharmacy licenses OR re-applying when a previous Delaware pharmacy license has lapsed and is no longer renewable. Since these licenses are not transferable, you must also file this application to report when an in-state pharmacy already licensed in Delaware:

- Changes ownership (controlling interest), or
- Relocates

### Requirements for All Applicants

Please read and follow instructions carefully. Failing to follow instructions will delay processing of your application.

- Submit completed, signed and notarized [Application for In-State Pharmacy Licensing](#).
  - Applications that are incomplete, unsigned or not notarized will be rejected.
- Arrange for the pharmacist-in-charge (PIC) to sign the **PHARMACIST-IN-CHARGE ACKNOWLEDGMENT** section.
  - A PIC must hold a current Delaware Pharmacist license.
  - A PIC may serve as a PIC for only one pharmacy at a time.
  - The PIC of a Nuclear Pharmacy must be a Qualified Nuclear Pharmacist. He/she is responsible for all Pharmacy operations and must be personally on the premises at all times that the Pharmacy is open for business.
  - If the PIC has not previously served as a pharmacist-in-charge in Delaware, he or she must appear personally at a [regularly scheduled Board meeting](#) within 90 days of assuming the position.
  - A PIC must complete the [Pharmacist-in-Charge Self-Inspection](#) form by February 1 of each year.
  - PIC changes must be reported to the Board of Pharmacy within 10 days of the change. Use the [Report of Pharmacist-in-Charge Change](#) form.
  - To receive news and alerts from the Delaware Board, a current email address is *essential*. As a Delaware-licensed Pharmacist, a PIC can keep his/her contact information up-to-date online at [Change Contact Information](#).
- Enclose non-refundable [processing fee](#) by check or money order made payable to the “State of Delaware.”
  - Applications submitted without the required fee will be rejected.
- Enclose a separate sheet showing the information at right for *each* owner, corporate officer, pharmacist and pharmacy employee listed on the application:
  - Name
  - Data of Birth
  - Social Security Number
  - Mailing Address

- Enclose three sets (copies) of the plans for the pharmacy department.
  - Plans must be drawn to scale and should include the location of the sink, all doors, storage room, approved Schedule II controlled substance safe, security systems, and counters. For specific requirements, refer to [24 Del.C. §2533](#) and Section 3.0 of the Board's [Rules and Regulations](#), both available at [www.dpr.delaware.gov](http://www.dpr.delaware.gov).
  - Plans must also show the type of alarm system installed and the name, address, and phone of the provider.
  - If the plans are for a nuclear pharmacy, the plans must show the radioactive storage and product decay area.
  
- Enclose sample patient profile that meets the requirements of Section 5.0 of the Board's [Rules and Regulations](#). **Label each of the following required items on the sample profile:**
  - Patient's family name and first name
  - Patient's address and phone number (or location in institution)
  - Patient's gender and age or date of birth
  - Original date the medication is dispensed following receipt of the prescription
  - Number or designation for prescription
  - Prescriber's name
  - Name, strength, quantity, directions and refill information of drug dispensed
    - Appropriate directions must also be present if medication is for patients in institutions.
  - Initials of dispensing pharmacist and date of dispensing medication as a refill if those initials and date are not recorded on original prescription
  - If patient refuses to give all or part of the required information, the pharmacist shall indicate and initial in the appropriate area
  - Pharmacist comments relevant to the patient's drug therapy, including any other information peculiar to the specific patient or drug
  - Annotate the patient's
    - allergies, idiosyncrasies, chronic diseases
    - frequently used over-the-counter medications
 If the answer is none, this must also be shown on the profile.

#### **Additional Requirement for Nuclear Pharmacies**

- Submit a copy of your approved Delaware Office of Radiation Control or Nuclear Regulatory Commission license.

#### **Inspection Requirement**

In addition to meeting all the requirements above, the pharmacy must be inspected before opening. A pharmacy representative **must notify the Board office** when the pharmacy is ready for inspection. When the pharmacy passes the final inspection, the Board office will issue the license.

#### **Reporting Remodeling of an In-State Pharmacy**

If an in-state pharmacy will be remodeling but **there is no change in ownership nor location**, file an [Application for In-State Remodeling Permit](#) instead of the *Application for In-State Pharmacy Permit*.

#### **Reporting an In-State Pharmacy Name Change**

If the in-state pharmacy's name changes but **there is no change in ownership nor location**, it is not necessary to submit an *Application for In-State Pharmacy Permit*. Instead, submit:

- Letter notifying the Board of the change that includes the pharmacy's old name, new name, license number and effective date of change.
- [Duplicate license fee](#) by check or money order made payable to the "State of Delaware."
  - The duplicate license will show the new name, but the license number will not change.

#### **Controlled Substances Registration**

If the in-state pharmacy stores and/or dispenses controlled substances, a separate [Controlled Substances Application for Facilities](#) is required.

**Before dispensing controlled substances in Delaware, a pharmacy must have a Delaware Pharmacy permit, Delaware controlled substance registration and federal DEA permit. All pharmacies dispensing controlled substances must report to the Delaware Prescription Monitoring Program (PMP). For instructions on registering for the PMP, see the [Dispenser's Implementation Guide](#).**



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<b>For Board of Pharmacy Use Only</b>
<input type="checkbox"/> Verification
<input type="checkbox"/> Background
<input type="checkbox"/> Office Approval
<input type="checkbox"/> Inspection

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**APPLICATION FOR IN-STATE PHARMACY PERMIT**

**TYPE OF APPLICATION**

1. Select the items that describe the type of application:

- Initial Application –
- This pharmacy has never held a Delaware Pharmacy license.
  - This pharmacy previously held Delaware Pharmacy license number **A** \_\_\_\_ - \_\_\_\_\_ that has lapsed and is no longer renewable.
- Application Due to Change of Ownership – Pharmacy license number **A** \_\_\_\_ - \_\_\_\_\_
- Application Due to Relocation – Pharmacy license number **A** \_\_\_\_ - \_\_\_\_\_

2. Select type of pharmacy:  **Retail** – Select type of retail outlet:  **Hospital** (In-patient dispensing *only*)

- Community
- Nuclear
- Specialty Institutional

**CONTACT AND LOCATION INFORMATION**

3. Name of Business (as it should appear on license): \_\_\_\_\_

4. Enter all other trade or business names you use (or have used) such as “doing business as” or “formerly known as” names: \_\_\_\_\_

5. **Location Address:** \_\_\_\_\_  
Street (No PO Boxes) Note: If you are reporting relocation, this is the *new* location.

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

6. Location Phone: \_\_\_\_\_

7. **Mailing Address** (if different from physical location): \_\_\_\_\_

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

8. Enter the name and email of the person who should be contacted for information about this application. The contact may be a representative in the corporate/district, an owner or the Pharmacist-in-Charge. An *Application Receipt* and any other correspondence about this application will be sent to the email address you enter here.

Contact Name: \_\_\_\_\_ Email: \_\_\_\_\_

**LICENSURE INFORMATION**

9. Will you store and/or dispense controlled substances?  
Yes  No

**Before dispensing controlled substances in Delaware, a pharmacy must have a Delaware Pharmacy permit, Delaware controlled substance registration and federal DEA permit. All pharmacies dispensing controlled substances must report to the Delaware Prescription Monitoring Program (PMP). For instructions on registering for the PMP, see the Dispenser’s Implementation Guide.**

10. If applying as a Nuclear Pharmacy, do you have a Delaware Office of Radiation Control and/or Nuclear Regulatory Commission license? Yes  No  **If yes, submit a copy of your Delaware Office of Radiation Control or Nuclear Regulatory Commission license.**

**OWNERSHIP INFORMATION**

11. Type of Business Owner (check one):

- Sole Proprietor – Continue with Question 12
- Individual with federal employee identification number – Continue with Question 12.
- Partnership – **Skip to** Question 13.
- Corporation – Enter Date of Corporate Charter: \_\_\_\_\_ **Skip to** Question 13.

12. Enter the following information about the owner and then skip to Question 14.

Full Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip

13. If a partnership, list **all active partners**. If a corporation, list **all principal officers**.

FULL NAME	TITLE

**Enclose a separate sheet listing name, date of birth, Social Security Number and mailing address for each person listed above.**

14. Do you understand that the Board must be notified within ten days of a change of ownership? Yes  No

**PHARMACIST AND EMPLOYEE INFORMATION**

15. Enter the following information about the Pharmacist-in-Charge:

Full Name: \_\_\_\_\_ Delaware License Number: **A1**- \_\_\_\_\_

**Arrange for the person named above to sign the *Pharmacist-in-Charge Acknowledgment* below. If this person has not previously served as a Pharmacist-in-Charge in Delaware, he or she must appear personally before the Board within 90 days of assuming the position.**

**PHARMACIST-IN-CHARGE ACKNOWLEDGMENT**

I understand that I am responsible for conducting and managing the prescription department in compliance with all applicable state and federal laws.

Have you read and understood your responsibilities in Section 3.1 of the Board’s [Rules and Regulations](#)? Yes  No

Do you agree to notify the Board of Pharmacy in writing within 10 days of your termination as pharmacist-in-charge? Yes  No

**Pharmacist-in-Charge Signature:** \_\_\_\_\_ Delaware License **A1** - \_\_\_\_\_

**Email:** \_\_\_\_\_

**To receive news and alerts from the Delaware Board, a current email address is essential. Keep all of your contact information up-to-date online at [Change Contact Information](#).**

16. List all other registered pharmacists who will be dispensing at the Pharmacy.

FULL NAME	LICENSE NUMBER
	A1- _____

Enclose a separate sheet listing name, date of birth, Social Security Number and mailing address for each person listed above.

17. List all unregistered employees who will be working in the Pharmacy.

FULL NAME	EMPLOYMENT START DATE

Enclose a separate sheet showing name, date of birth, Social Security Number and mailing address for each person listed above.

**INFORMATION ABOUT PHARMACY SERVICES**

18. Check all pharmacy services offered:

- Dispense non-controlled substances
- Dispense controlled substances
- Sterile compounding – check all that apply:
  - LOW RISK
  - MEDIUM RISK
  - HIGH RISK
- Non-sterile compounding
- Wholesale distribution
- Pharmaceutical manufacturing
- Mail order
- Long-term care
- Nuclear

19. Will you offer any of the above services to patients who are not in Delaware? Yes  No

20. Will you provide **non-sterile** compounding? Yes  No  If yes, check all that apply:

- Pursuant to patient-specific prescription
- In bulk – compounding multiple doses from a single source or batch
- In bulk – for office use

21. Will you provide **sterile** compounding? Yes  No  If yes, check all that apply:

- Pursuant to patient-specific prescription
- In bulk – compounding multiple doses from a single source or batch
- In bulk – for office use

22. Will you compound in bulk, whether sterile or non-sterile? Yes  No  If yes, indicate your largest number of doses from a single batch:  24 or fewer  24 – 49  50 – 100  100 or more

23. Will you provide **sterile** compounding? Yes  No  If yes, check all types of substances compounded:

- |   |   |
|---|---|
| <input type="checkbox"/> Total parenteral nutrition (TPN) | <input type="checkbox"/> Aqueous inhalant solutions for respiratory |
| <input type="checkbox"/> Parenteral antibiotics           | <input type="checkbox"/> Parenteral antineoplastic agents           |
| <input type="checkbox"/> Parenteral electrolytes          | <input type="checkbox"/> Parenteral vitamins                        |
| <input type="checkbox"/> Irrigating fluids                | <input type="checkbox"/> Ophthalmic preparations                    |
| <input type="checkbox"/> Parenteral analgesics            | <input type="checkbox"/> Other: _____                               |

### INFORMATION ABOUT OUTSOURCING SERVICES

24. Will this pharmacy compound sterile drugs without a prescription and distribute them in Delaware? Yes  No  **If yes, the facility is an outsourcing facility as defined in Section 503B, [Registration of Outsourcing Facilities and Reporting of Drugs](#), of the federal Food, Drug, and Cosmetics Act. You must complete and submit an [Application for Outsourcing Facility](#) in addition to this application.**

### INFORMATION ABOUT PHARMACY OPERATION

25. Pharmacy Department hours:

Weekdays	_____	AM to	_____	PM
Saturday	_____	AM to	_____	PM
Sunday	_____	AM to	_____	PM
Holidays	_____	AM to	_____	PM

26. Enter Hours of Business Site:

Weekdays	_____	AM to	_____	PM
Saturday	_____	AM to	_____	PM
Sunday	_____	AM to	_____	PM
Holidays	_____	AM to	_____	PM

27. The Prescription Department must occupy at least 250 square feet of floor space excluding a storeroom. The prescription counter must be at least 18 inches wide with four linear feet kept clear and free of all merchandise for each pharmacist working concurrently. The aisle behind the counter must be at least 30 inches wide and shall be kept free of obstruction at all times. Are these requirements met? Yes  No

28. Will the pharmacy have sufficient size, space, sanitation, and environmental control for adequate distribution, dispensing, and storage of drugs and devices? Yes  No

29. Will the pharmacy have a dispensing area of adequate size and space for proper compounding, dispensing, and storage of drugs and devices, to ensure the safety and well being of the public and pharmacy personnel? Yes  No

30. The area in which drugs and devices are stored must be accurately monitored using control devices to maintain room temperature between 59° and 86° Fahrenheit. Will the pharmacy have sufficient environmental control, i.e. lighting, ventilation, heating, and cooling, to maintain the integrity of drugs and devices? Yes  No

31. The sink in the pharmacy area must be large enough to accommodate the equipment required by the Board so that the utensils can be properly washed and sanitized. Will the pharmacy contain a sink with hot and cold running water? Yes  No

32. Refrigerators and freezers (where required) will be maintained at the USP/NF range: Refrigerator – 36 ° to 46 ° Fahrenheit; Freezer – minus 4 ° to plus 14 ° Fahrenheit. Will the pharmacy have suitable refrigeration with appropriate monitoring device? Yes  No

33. An area must be provided to afford the patient privacy from auditory detection by any unauthorized person(s). In most settings, an area partitioned with a minimum of 9 square feet will satisfy this requirement. Will the pharmacy have an area which assures patient privacy to facilitate counseling? Yes  No

34. A sign, with letters not less than 3/4" in height, in the vicinity of the prescription department and visible to the public must list the names of the pharmacists employed at that pharmacy or the name of the pharmacist on duty. Will the pharmacy meet this requirement? Yes  No

35. Do the floor plans for the pharmacy include the type of alarm system installed and the name, address, and phone number of the provider? Yes  No
36. The pharmacy must have floor-to-ceiling physical barriers, motion detectors, and surveillance cameras that meet the standards in Section 5.0 of the [Uniform Controlled Substances Act Regulations](#). Will the pharmacy meet this requirement? Yes  No
37. No one but a pharmacist is allowed to unlock and lock the prescription department. Will the pharmacy meet this requirement? Yes  No
38. Each pharmacy is required to maintain a library of the latest edition and supplements of current reference sources (either hard copy or electronic) appropriate to the practice and to the care of the patient served. Will the pharmacy meet this requirement? Yes  No  If yes, explain how you will assure that current information is readily available (e.g., FDA website): \_\_\_\_\_
39. The pharmacy must maintain the following records:
- the original of every prescription compounded or dispensed at the pharmacy for a period of at least three years
  - patient profile record for a period of at least one year from the date of the last entry in the profile record unless it is also used as a dispensing record.
  - (*Nuclear Pharmacies only*) records of acquisition, inventory, and disposition of all radioactive drugs and other radioactive materials in accordance with NRC statute(s) and regulation(s)

Will the pharmacy meet these recordkeeping requirements? Yes  No

40. When receiving a new prescription, a pharmacist (or pharmacy intern under the direct supervision of a pharmacist) must examine the patient profile before dispensing the medication to determine the possibility of a harmful drug interaction or reaction. If a potential harmful reaction or interaction is recognized, the pharmacist must take appropriate action to avoid or minimize the problem, including consultation with the physician as necessary. Will the pharmacy meet this requirement? Yes  No
- **Enclose three sets (copies) of the plans for the pharmacy department. Plans must be drawn to scale and should include the location of the sink, all doors, storage room, approved Schedule II controlled substance safe, security systems, and counters. If applying as a Nuclear Pharmacy, the plans must show a radioactive storage and product decay area.**
  - **Enclose a sample patient profile. See the Instruction Sheet for checklist of items that must appear on the sample.**

## DISCLOSURES

41. Have any of the owners, corporate officers, pharmacists or unregistered employees listed on this application ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense, including any offense for which they have received a pardon, in any jurisdiction? Yes  No  **If yes, submit a certified copy of the criminal history record from any jurisdiction where they have been convicted or pardoned. For information on obtaining a Delaware criminal history record, see [State Bureau of Identification](#).**
42. Are any of the owners, corporate officers, pharmacists or unregistered employees listed above presently charged with committing a felony? Yes  No  **If yes, explain in detail on a separate sheet.**
43. Have any of the owners, corporate officers or pharmacists listed above ever applied for a pharmacy permit or controlled substances registration in any State and had the application denied? Yes  No  **If yes, explain in detail on a separate sheet.**
44. Has any of the owners, corporate officers or pharmacists listed above ever been the subject of any disciplinary action (formal or informal) by any federal or state agency or any hospital credentials committee including, but not limited to, revocation or suspension of a controlled substance registration or is any such action pending? Yes  No  **If yes, explain in detail on a separate sheet and enclose any relevant documents.**

**DUTY TO REPORT**

45. To obtain a Delaware permit as an In-State Pharmacy, you must certify that the owners, corporate officers, pharmacists and unregistered persons listed on this application understand that they each have a **mandatory** obligation to file a written report with the Delaware Board of Medical Licensure and Discipline within 30 days if they have any reason to believe that a Delaware-licensed medical practitioner is (or may be) guilty of unprofessional conduct as defined in 24 *Del. C.* §1731 OR that he/she is (or may be):

- medically incompetent
- mentally or physically unable to engage safely in the practice of medicine
- excessively using or abusing drugs including alcohol.

I certify that the owners, corporate officers and pharmacists listed on this application have read the provisions of [24 Del. C. §1730, 24 Del. C. §1731 and 24 Del. C. §1731A](#) and that they understand their *duty to report*. Yes  No

46. To obtain a Delaware permit as an In-State Pharmacy, you must certify that the owners, corporate officers, pharmacists and unregistered persons listed on this application understand that they each have a **mandatory** obligation to make an immediate oral report to the Delaware Department of Services for Children, Youth and Their Families if they know of, or they suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

I certify that the owners, corporate officers and pharmacists listed on this application have read [16 Del. C. §903](#) and that they understand their *duty to report*. Yes  No

**When your application is complete, please allow 4-8 weeks to receive your permit. A complete application is one that includes all required documentation and correct payment. Applications that are not complete within six months of filing may be considered abandoned and discarded.**

**AFFIDAVIT**

**I hereby swear or affirm that the foregoing statements are correct and do hereby agree to abide by the pharmacy laws of the State of Delaware and to all rules and regulations of the Delaware State Board of Pharmacy.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**State:** \_\_\_\_\_ **County:** \_\_\_\_\_

Sworn or affirmed before me a Notary Public this \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_\_

**Notary Public:** \_\_\_\_\_

SEAL

My commission expires on \_\_\_\_\_

**APPLICATIONS THAT ARE NOT SIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.**