ILLINOIS PHARMACY LICENSE APPLICATION INSTRUCTIONS

This application is for any of the following situations:

- Apply for a NEW Illinois pharmacy license.
- CHANGE OF OWNERSHIP, REORGANIZATION, or CONVERSION.
- RELOCATION.
- CHANGE OF NAME or ASSUMED NAME.
- ADD or CHANGE PHARMACY OPERATIONS.

Do NOT complete this application for:

- Change of Pharmacist-in-Charge only.
  (Submit a separate Change of Pharmacist-in-Charge application, available online at **www.idfpr.illinois.gov**)

The fee for a pharmacy license is $100. Make your check or money order payable to IDFPR. **The fee is not refundable.** Applications received without the proper fee will not be processed.

FAILURE TO COMPLETE THE ENTIRE APPLICATION WILL RESULT IN DELAYS FOR YOUR APPLICATION. Fill in every box on the application. Use N/A sparingly for Not Applicable or Not Available. Read the remainder of the instructions *carefully* before completing the application. The Illinois Pharmacy Act and the Rules for the Administration of the Act with all pharmacy requirements are available online at: **http://www.idfpr.com/profs/info/Pharm.asp**

On a separate sheet of paper supply names, home addresses, and registered pharmacist numbers of all owners, partners, members, officers, directors, or shareholders owning 5% or more of the outstanding shares.

Corporations or LLCs must submit a copy of their filed Articles of Incorporation/Organization.

Partnerships, Corporations or LLCs must submit a copy of their most recent annual report.

Foreign Corporations (Businesses incorporated/organized outside of Illinois) with a pharmacy located inside Illinois must submit a Certificate of Authority from the Illinois Secretary of State.

Partnerships, Corporations or LLCs **Doing-Business-As (DBA)** or operating under an **Assumed Name** must submit documentation of registering the name with:

Sole Proprietor/ Partnership:	County Clerk's Office where the assumed name is filed.
Corporation/ LLCs:	Illinois Secretary of State (or other jurisdiction's business authority).

Pharmacies **located outside of Illinois (non-resident)** must submit:

- ☐ Certification of Licensure (form CT-PH) completed by the Pharmacy licensure authority in the state where the pharmacy is located (The name and address should match the name and address on your application); **AND**
- ☐ A photocopy of the current pharmacy license and controlled substance license for the state where the pharmacy is located (The name and address should match the name and address on your application); **AND**
- ☐ A photocopy of your current DEA registration (The name, address, and drug schedules should match the name, address, and drug schedules on your application); **AND**
- ☐ A photocopy of your most recent inspection report (The name and address should match the name and address on your application).
- ☐ Applications to CHANGE OWNERSHIP/ADDRESS (for pharmacies located outside Illinois) must return their current, original Illinois Pharmacy license (and Controlled Substances license, if applicable). You are permitted to keep for your records a photocopy of the license. You must return the original.

For help completing this application, call

1-800-560-6420.

Completed application, supporting documents, and fee are to be sent to:

Illinois Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
P.O. Box 7007
Springfield, Illinois 62791

After the application is reviewed, in-state pharmacies must be inspected and approved by a Department of Financial and Professional Regulation pharmacy investigator before a license will be issued. You will be contacted by the pharmacy investigator to arrange for inspection. **A pharmacy may not operate until a license is issued. Any operation without a license is considered unlicensed practice by the Department and therefore subject to discipline.**

Please note that pharmacies licensed in Illinois are required to comply with the Methamphetamine Precursor Tracking Act, 720 ILCS 649/1, et. seq.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

FOR OFFICIAL USE ONLY

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

APPLICATION FOR A LICENSED PHARMACY

1. APPLICATION TYPE ☐ New License ☐ Change of Ownership / Reorganization / Conversion ☐ Add / Change of Pharmacy Operations ☐ Change of Name / Assumed Name ☐ Relocation

PROF CODE **054**

2. TYPE OF PHARMACY OPERATIONS (check all that apply):

☐ Community Pharmacy
☐ Nonresident Pharmacy
☐ Nuclear Pharmacy
☐ Sterile Compounding Pharmacy
☐ Offsite Institutional Pharmacy
☐ Onsite Institutional Pharmacy
☐ Remote Prescription / Medication Order Processing
☐ Remote Dispensing Pharmacy
☐ Remote Automatic Pharmacy
☐ Remote Consultation Pharmacy

Home Pharmacy License #: _____

3. NAME OF PARTNERSHIP, CORPORATION, OR LLC (SOLE PROPRIETOR PUT N/A)

4. DOING BUSINESS AS (DBA) / ASSUMED NAME (PHARMACY NAME)

5. NAME OF PHARMACIST-IN-CHARGE

6. PHARMACIST-IN-CHARGE LICENSE NUMBER

7. ADDRESS OF PHARMACY (include Street **no P.O. Boxes**, Ste #, City, State, ZIP Code)

8. COUNTY

9. FEIN OR SOCIAL SECURITY NO.

10. TELEPHONE NUMBER (Include Area Code)

11. Preferred email address

12. Web address (if applicable):

13. NAME AND TITLE OF DESIGNATED PARTNER/CORPORATE OFFICER OR OWNER

14. HOME ADDRESS OF DESIGNATED PARTNER/CORPORATE OFFICER OR OWNER

15. ILLINOIS LICENSE NO. OF OWNER OR DESIGNATED PARTNER/CORPORATE OFFICER

16. TELEPHONE NUMBER OF DESIGNATED PARTNER/CORPORATE OFFICER OR OWNER (Include Area Code)

17. OWNERSHIP OF PHARMACY (check one):

☐ Pharmacist Sole Proprietor

☐ Non-Pharmacist Sole Proprietor

☐ Partnership - Designated Partner *(On separate sheet, supply names, home addresses, and Registered Pharmacist number (if any) of all partners.)*

☐ LLC - Officer, directors and members. *(On a separate sheet, supply names, home addresses and Registered Pharmacist numbers (if any) of all officers, directors and members owning 5% or more of the outstanding shares. Additionally, attach a copy of the Articles of Organization and annual report.)*

☐ Corporation - Designated Officer *(On separate sheet, supply names, home addresses, and Registered Pharmacist numbers (if any) of all officers, directors, and shareholders owning 5% or more of the outstanding shares. Additionally, attach a copy of the Articles of Incorporation and annual report.)*

SECTION I. COMPLETE ONLY IF A NON-RESIDENT PHARMACY

a. Current State License No.

b. DEA No.

c. State Issued Controlled Substance License No.

d. Toll-Free Telephone No.

SECTION II. COMPLETE ONLY IF CHANGE OF OWNERSHIP

a. Previous Name of Pharmacy

b. Previous Illinois License No.

c. Date of Acquisition

SECTION III. COMPLETE ALL AREAS THAT APPLY

a. Date of Proposed Opening

b. Previous License No. (If Applicable)

c. PREVIOUS NAME AND ADDRESS IF CHANGE OF ADDRESS

PERSONAL HISTORY INFORMATION

1. Have you, or any names therein listed, ever been charged in a court of law, hearing or other administrative procedure with any violation of the laws of the United States or of any individual state relating to the practice of pharmacy, drugs, liquor, poisonous substances or any felony offense? ☐ Yes ☐ No
   (If "Yes," state all particulars, dates, places, and certified court documents relating to the offense, a brief explanation of the events of the offense and the present status on a separate sheet of paper.)

2. Have you been an owner of a pharmacy (partner, director, etc.) in or outside the State of Illinois that had its certificate or registration revoked or suspended? ☐ Yes ☐ No

3. During regular hours of operation, non-resident pharmacies must provide a toll-free telephone service to facilitate communications between patients in this State and a pharmacist at the pharmacy who has access to the patient's records. The toll-free number must be disclosed on the label affixed to each container of drugs dispensed to residents of this State.

   Does your pharmacy meet the requirement as set for **above and** Section 16a of the Illinois Pharmacy Practice Act? ☐ Yes ☐ No

4. In the course of operation, will pharmacy dispense Controlled Substances in Illinois? ☐ Yes ☐ No
   (If answer is "Yes," you are required to submit an Illinois Controlled Substance application.)

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete; and I hereby declare that, if the certificate of registration for the pharmacy herein described is granted, such pharmacy will (a) be engaged in the practice of pharmacy, (b) have in stock and maintain sufficient drugs and medicines within 30 days after the issuance of a certificate of registration if required, (c) have and maintain adequate space for a prescription department, (d) be operated in conformity with all applicable local, state, and federal laws. I further declare that the Illinois Department of Financial and Professional Regulation will be promptly notified of the effective date of any change of ownership, name, and address of the pharmacy or pharmacist-in-charge and all applicable fees and aplications will be submitted to the Department in a timely manner in accordance with the Illinois Pharmacy Practice Act and the Rules for the Administration of the Act.

Type or Print Name of Owner or Person Designated to Sign for Firm

Signature of Owner or Person Designated to Sign for Firm

Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $25.

Name of Pharmacy:

FEIN or SS#:

Profession Name: PHARMACY

The pharmacist-in-charge must complete the area below which applies to him/her.

A. NAME OF PHARMACIST-IN-CHARGE	B. BIRTH DATE	C. LICENSE NUMBER
D. HOME ADDRESS (Street, City, State, ZIP Code)	E. HOME TELEPHONE NUMBER Area Code (__ __ __) __ __ __ - __ __ __ __	
	F. DRIVER'S LICENSE NUMBER OR OTHER ID NUMBER	G. INDICATE TYPE OF ID

1. Have you ever been charged in a court of law, hearing or other administrative procedure with any violation of the laws of the United States or of any individual state relating to the practice of pharmacy, drugs, liquor, poisonous substances or any felony offense? ☐ Yes ☐ No *(If "Yes," state all particulars, dates, places, and present status on separate sheet and include certified court documents related to the offense(s).)*

2. Have you been an owner of a pharmacy that had its certificate of registration disciplined? ☐ Yes ☐ No *(If "Yes," provide all details on a separate sheet.) (NOTE: Owner is defined as sole proprietor, partner or shareholder who owns in excess of 5 percent of the outstanding shares of a corporation, or the spouse or children of such proprietor, partner, or shareholder, excluding publicly traded stocks.)*

3. I will be in physically present at the pharmacy for a minimum of eight hours per week. ☐ Yes ☐ No

4. I will notify the Department within 30 days of my departure as pharmacist-in-charge in writing. ☐ Yes ☐ No

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me or the owner in connection therewith, and to the best of my knowledge, they are true, correct, and complete; and I hereby declare that, if the certificate of registration for the pharmacy herein described is granted, such pharmacy will (a) be engaged in the practice of pharmacy, (b) have in stock and maintain sufficient drugs and medicines within 30 days after the issuance of a certificate of registration if required, (c) have and maintain adequate space for a prescription department, (d) be operated in conformity with all applicable local, state, and federal laws. I further declare that the Illinois Department of Financial and Professional Regulation will be promptly notified of the effective date of any change of ownership, name, and address of the pharmacy or pharmacist-in-charge.

Signature of Pharmacist-in-Charge: _____

Name of Pharmacy:

FEIN or SS#:

Profession Name: PHARMACY

PHARMACY
APPLICATION FOR A LICENSE UNDER THE ILLINOIS CONTROLLED SUBSTANCES ACT

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is required by 720 of the Illinois Compiled Statutes. Disclosure of this information is "MANDATORY." However, failure to comply could result in a fine up to $30,000.

1. Every person who dispenses any controlled substances within the State of Illinois must obtain a registration issued by the Department of Financial and Professional Regulation in accordance with the Illinois Controlled Substances Act.
2. A State Controlled Substances Registration is prerequisite to a Federal Controlled Substances Registration (DEA).

A. Type or print legibly with black ink only.
B. The fee is $5 - Make check payable to the Department of Financial and Professional Regulation. The fee is not refundable.
C. Submit application and fee to:
Department of Financial and Professional Regulation
Attn: Division of Professional Regulation
P. O. Box 7007
Springfield, Illinois 62791

PART I: Application Category Information

1. PROFESSION NAME	2. PROF CODE	3. LICENSURE METHOD	4. FEE
Pharmacy Controlled Substances	**3 2 0**	**Registration**	**$5.00**

PART II: Application Identifying Information

1. NAME OF PARTNERSHIP, CORPORATION, OR LLC (SOLE PROPRIETOR PUT N/A)
2. EMAIL ADDRESS (REQUIRED)
3. DBA / ASSUMED NAME (PHARMACY NAME)
4. FEIN NUMBER
5. TELEPHONE NUMBER (Include Area Code) (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___
6. ADDRESS STREET CITY STATE ZIP CODE COUNTY
7. R.PH IN CHARGE
8. LICENSE NUMBER
9. SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___
10. DATE OF BIRTH ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year)

PART III: Drug Schedules (Circle all applicable)

II III IV V

1. Has applicant, or any names therein listed, ever been charged in a court of law, hearing, or other administrative procedure with any violation of the laws of the United States or of any individual state, relating to drugs, liquor, poisonous substance or any felony offense?
☐ Yes ☐ No *(If "Yes," state all particulars, dates, places, and present status on separate sheet.)*

2. Has applicant, or any persons listed above, ever had any disciplinary action taken against him or been convicted of any violation of the laws of the United States or of any individual state, relating to the manufacture, distribution, or dispensing of Controlled Substances?
☐ Yes ☐ No *(If "Yes," state all particulars, dates, places, and present status on separate sheet.)*

I hereby certify that I personally completed this application, that the answers appearing hereon are true and correct to the best of my knowledge and belief, and that I am legally authorized to sign for this business.

Print Name of Owner or Person Designated to Sign for Business

Signature of Owner or Person Designated to Sign for Business

Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 120 (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

PHARMACY

CERTIFICATION BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

CT-PH

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. You are authorized to photocopy this form as necessary.

1. NAME OF BUSINESS, CORPORATION, OR LLC			
2. DBA (ASSUMED NAME)			3. FEIN
4. FACILITY STREET ADDRESS		5. EMAIL ADDRESS (REQUIRED)	
6. FACILITY CITY	7. STATE	8. ZIP CODE	9. TELEPHONE NUMBER (include Area Code)

I hereby authorize _____ to furnish to the Illinois Department of
Other State Licensing Agency
Financial and Professional Regulation the information requested below.

Date _____ Signature of Applicant _____

DO NOT RETURN COMPLETED FORM TO APPLICANT

OTHER STATE LICENSING AGENCY: **The Illinois Department of Financial and Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the Certification. Please record N/A in areas which are not applicable.**

A. LICENSE NUMBER		F. TYPE OF LICENSE
B. LICENSE STATUS		☐ Pharmacy ☐ Wholesale Drug Distributor/Manufacturer ☐ Third Party Logistics (3PL) Provider ☐ Home Medical Equipment / Durable Medical Equipment ☐ Other _____
C. DATE ISSUED	D. DATE LICENSE EXPIRES	
E. HAS THIS LICENSE BEEN ENCUMBERED IN ANY WAY? _____ Yes _____ No **If "yes," please attach certified copies of all pertinent legal documents.**		G. TYPE OF ENCUMBERANCE ☐ Revoked ☐ Suspended / Restricted ☐ Surrendered ☐ Probation ☐ Limited

USE REVERSE SIDE OF THIS FORM FOR EXPLANATIONS.

1. Has the applicant been convicted under any federal, state, or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of controlled substances, or the provision of home medical equipment and its services? ☐ Yes ☐ No
2. Has the applicant furnished any false or fraudulent material in any application made in connection with a pharmacy operation, drug manufacturing or distribution, or home medical equipment or its services? ☐ Yes ☐ No
3. Have any inspections resulted in deficiency ratings? (If yes, please explain.) ☐ Yes ☐ No
4. Has the applicant met all licensing requirements in your state? ☐ Yes ☐ No

BOARD SEAL AREA (affix official State Seal of licensing agency below) SEAL	**RETURN FORM TO:** Illinois Department of Financial and Professional Regulation Health Services Section 320 W. Washington Springfield, Illinois 62786
Signature	**Title**
State	**Date**