

## 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](http://www.idfpr.illinois.gov))

The fee for a pharmacy license is \$600. 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:  
Corporation/ LLCs:

County Clerk's Office where the assumed name is filed.  
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	<input type="checkbox"/> New License	<input type="checkbox"/> Change of Ownership / Reorganization / Conversion	PROF CODE
	<input type="checkbox"/> Add / Change of Pharmacy Operations	<input type="checkbox"/> Change of Name / Assumed Name	<b>054</b>
		<input type="checkbox"/> Relocation	

2. TYPE OF PHARMACY OPERATIONS (check all that apply):	<input type="checkbox"/> Remote Dispensing Pharmacy
<input type="checkbox"/> Community Pharmacy	<input type="checkbox"/> Remote Automatic Pharmacy
<input type="checkbox"/> Nonresident Pharmacy	<input type="checkbox"/> Remote Consultation Pharmacy
<input type="checkbox"/> Nuclear Pharmacy	Home Pharmacy License #:
<input type="checkbox"/> Sterile Compounding Pharmacy	_____
<input type="checkbox"/> Outpatient Clinical Pharmacy	
<input type="checkbox"/> Offsite Institutional Pharmacy	
<input type="checkbox"/> Onsite Institutional Pharmacy	
<input type="checkbox"/> Remote Prescription Medication Order Processing	
<input type="checkbox"/> Centralized Prescription Filling	

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

8. COUNTY	9. FEIN OR SSN OR ITIN	10. TELEPHONE NUMBER (Include Area Code)
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11. Preferred email address	12. Web address (if applicable):
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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.
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d. Toll-Free Telephone No.

**SECTION II. COMPLETE ONLY IF CHANGE OF OWNERSHIP**

a. Previous Name of Pharmacy	b. Previous Illinois License No.
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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 applications 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.

Legal Name of Business:

FEIN or SSN or ITIN:

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: \_\_\_\_\_

Legal Name of Business: \_\_\_\_\_

FEIN or SSN or ITIN: \_\_\_\_\_

Profession Name: PHARMACY



**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 Financial and Professional Regulation the information requested below.  
Other State Licensing Agency

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		<input type="checkbox"/> Pharmacy <input type="checkbox"/> Wholesale Drug Distributor/Manufacturer <input type="checkbox"/> Third Party Logistics (3PL) Provider <input type="checkbox"/> Home Medical Equipment / Durable Medical Equipment <input type="checkbox"/> 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 <input type="checkbox"/> Revoked <input type="checkbox"/> Suspended / Restricted <input type="checkbox"/> Surrendered <input type="checkbox"/> Probation <input type="checkbox"/> Limited	

**USE REVERSE SIDE OF THIS FORM FOR EXPLANATIONS.**

- 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
- 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
- Have any inspections resulted in deficiency ratings? (If yes, please explain.)  Yes     No
- Has the applicant met all licensing requirements in your state?  Yes     No

BOARD SEAL AREA (affix official State Seal of licensing agency below)  <p align="center">S E A L</p>	<b>RETURN FORM TO:</b> Illinois Department of Financial and Professional Regulation Health Services Section 320 W. Washington Springfield, Illinois 62786
Signature	Title
State	Date