

## REQUIREMENTS AND INSTRUCTIONS FOR FILING - PHARMACY

Access this form via website at: [www.hawaii.gov/dcca/areas/pvl](http://www.hawaii.gov/dcca/areas/pvl)

### APPLICATION FORM

Type or print *legibly* in dark ink.

Failure to provide the requested information will delay the processing of your application.

### SOCIAL SECURITY NUMBER

Your social security number is used to verify your identity for licensing purposes and for compliance with the below laws. For a license to be issued you must **provide your social security number or your application will be deemed deficient and will not be processed further.**

The following laws require that you furnish your social security number to our agency:

#### FEDERAL LAWS:

**42 U.S.C.A. §666(a)(13)** requires the social security number of any applicant for a professional license or occupational license be recorded on the application for license; and

If you are a licensed health care practitioner, **45 C.F.R., Part 61, Subpart B, §61.7** requires the social security number as part of the mandatory reporting we must do to the Healthcare Integrity and Protection Data Bank (HIPDB), of any final adverse licensing action against a licensed health care practitioner.

#### HAWAII REVISED STATUTES ("HRS"):

**§576D-13(j), HRS** requires the social security number of any applicant for a professional license or occupational license be recorded on the application for license; and

**§436B-10(4) HRS** which states that an applicant for license shall provide the applicant's social security number if the licensing authority is authorized by federal law to require the disclosure (and by the federal cites shown above, we are authorized to require the social security number).

### SELF-INSPECTION REPORT

Complete Pharmacy Self-Inspection Report and **attach** a diagram of the floor plan of the premises showing the specific location of the prescription area. Diagram the space and location of fixtures such as counters, tables, drawers, shelves, storage cabinets including a locked cabinet, library, sink with hot and cold water, proper sewage outlet, and refrigeration storage equipment. Identify the spaces and equipment. **Attach** photographs with captions to depict the above.

### SECURITY DESCRIPTION

Complete "Security of Pharmacy Prescription Area", (PH-24) form.

### ENTITY REGISTRATION

If the applicant is a corporation, partnership, LLC, or LLP, submit the following proof to show that the entity is properly registered with the Business Registration Division (BREG), Department of Commerce and Consumer Affairs, State of Hawaii (phone (808) 586-2727) or visit their website at: [www.businessregistrations.com/home.html](http://www.businessregistrations.com/home.html) to order Certificates of Good Standing, forms, etc.

If the corporation/partnership/LLC/LLP has been registered in this state for LESS THAN ONE (1) YEAR, **ATTACH** a "*filed-stamped*" copy of the document filed with BREG; or the same certificate mentioned below.

If the corporation/partnership/LLC/LLP has been registered in this state for MORE THAN ONE (1) year, **ATTACH** a current "*Certificate of Good Standing*" or "*Certificate of Qualification*" issued not more than 1 year ago.

### TRADE NAME

If you are planning to use a trade name, **attach** a current "filed-stamped" copy of the "Application for Registration of Trade Name" approved by the Business Registration Division of the Department of Commerce and Consumer Affairs. You may contact them at (808) 586-2727.

### RELOCATION OF PHARMACY

If filing for relocation of the pharmacy, complete and file the attached application, new self-inspection report including floor plans, photos, etc. and the non-refundable application fee of \$100.

### NEW LICENSE-BUSINESS FORMERLY OWNED BY SOMEONE ELSE

**ATTACH** a letter of verification from the former owner that the pharmacy has been bought with the effective date of sale.

(Continued)

**FEES**

Make check payable to *COMMERCE & CONSUMER AFFAIRS* for the applicable fees:

If applying for license in an EVEN-NUMBERED year, pay .....\$295  
*(\*Application fee-\$100, License-\$50, 1/2 renewal-\$75, Compliance Resolution Fund-\$70).*

If applying for license in an ODD-NUMBERED year, pay ..... \$185\*\*  
*(\*Application fee-\$100, License-\$50, Compliance Resolution Fund-\$35).*

**If applying for Relocation, pay .....\$100**  
***(Application fee-\$100, license fees are not required).***

\* *Application fee is nonrefundable.*

\*\* *ALL licenses expire on December 31, ODD-NUMBERED years and are subject to renewal regardless of license issuance date.*

**NOTE:** *One of the numerous legal requirements that you must meet in order for your new license to be issued is the payment of fees as set forth in this application. You may be sent a license certificate before the payment you sent us for your required fees is honored by your bank. If your payment is dishonored, you will have failed to pay the required licensing fee and your license will not be valid, and you **may not** do business under that license. Also, a \$25.00 service charge shall be assessed for payments that are dishonored for any reason.*

*If for any reason you are denied the license you are applying for, you may be entitled to a hearing as provided by Title 16, Chapter 201, Hawaii Administrative Rules, and/or Chapter 91, Hawaii Revised Statutes. Your written request for a hearing must be directed to the agency that denied your application, and must be made within 60 days of notification that your application for a license has been denied.*

**ADDRESS OF BOARD**

Mail all required items to:

*Board of Pharmacy  
DCCA, PVL Licensing Branch                    or  
P. O. Box 3469  
Honolulu, HI 96801*

Deliver to office location:

*335 Merchant Street, Room 301  
Honolulu, HI 96813  
Phone: (808) 586-3000*

**LAWS & RULES PUBLICATION**

The license holder is held accountable for knowing and complying with the laws and rules relating to pharmacy practice as failure to comply may result in disciplinary action.

Copies of the laws and rules relating to the practice of pharmacy may be obtained by submitting a written request to: Board of Pharmacy, COMMERCE & CONSUMER AFFAIRS, *P. O. Box 3469, Honolulu, HI 96801.* Chapter 436B, Hawaii Revised Statutes, the Professional and Vocational Licensing Act should be read in conjunction with the chapters below.

- Chapter 461, Hawaii Revised Statutes, Pharmacists & Pharmacies
- Title 16, Chapter 95, Hawaii Administrative Rules, Pharmacists & Pharmacies
- Chapter 328, Hawaii Revised Statutes, Food, Drugs, & Cosmetics
- Chapter 329, Hawaii Revised Statutes, Uniform Controlled Substances Act

The laws and rules are also posted on our website at: [www.hawaii.gov/dcca/areas/pvl](http://www.hawaii.gov/dcca/areas/pvl). Click on "Pharmacy".

**BIENNIAL RENEWAL**

All licenses, regardless of issuance date, are subject to renewal on or before December 31, of each ODD-NUMBERED year.

The failure to timely renew a license, including payment of fees shall cause the license to be automatically forfeited. A license which has been forfeited may be restored within three (3) years after the date of forfeiture upon compliance with the licensing renewal requirements. After 3 years, a new application for license shall be required.

**ABANDONMENT  
OF APPLICATION**

Pursuant to HRS §436B-9 your application shall be considered abandoned and shall be destroyed if you fail to provide evidence of continued efforts to complete the licensing process for two consecutive years. The failure to provide evidence of continued efforts includes but is not limited to: (1) failure to submit any required information and documents requested by the licensing authority within two consecutive years from the last date the documents and information were requested, or (2) failure to complete any additional requirements for licensure that remain after approval of your application, such as attempting to complete an exam requirement, within two consecutive years from the date your application was approved, or (3) failure to provide the licensing authority with any written communication during two consecutive years indicating that you are attempting to complete the licensing process. If an application is deemed abandoned the applicant shall be required to reapply for licensure and comply with the licensing requirements in effect at the time of the reapplication.

**MATERIAL & EQUIPMENT REQUIREMENTS**

Each pharmacy shall at all times possess the following minimum professional and technical equipment.

**REFERENCE LIBRARY**

- Federal Drug Enforcement Agency Regulations
- The Uniform Controlled Substances Law, HRS, Chapter 329
- State Food & Drug Laws, HRS, Chapter 328
- State Pharmacy Law, HRS, Chapter 461
- Pharmacy Administrative Rules, HAR, Chapter 16-95
- Prescription files

**TECHNICAL EQUIPMENT**

Equipment for dispensing and compounding shall include:

- Class A prescription balance or a balance of greater sensitivity and appropriate weights
- Mortar and pestle - Glass or porcelain
- Refrigerator
- Bottles and vials - Various sizes
- Graduates or other similar measuring devices
- Prescription labels

**ATTACHED TO THIS APPLICATION ARE:**

- Proof of Business Registration
- Proof of trade name (if used) registration
- Proof of sale (to include date of sale), if pharmacy had a previous owner
- Floor plan which diagrams location of fixtures and equipment
- Pharmacy self-inspection report, signed
- Description of security system
- Photographs that document prescription area, including fixtures, sinks, equipment, and security system
- Fees

This material can be made available for individuals with special needs. Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

**APPLICATION FOR LICENSE – PHARMACY or  
RELOCATION OF PHARMACY**

PHY Checkout

- Fees: \$295 / \$185 / \$100
- Self-inspection report       Current PIC
- Security description       Bregs

**Circle type of business entity:**

INDIVIDUAL (Sole Owner)      CORPORATION      PARTNERSHIP  
LIMITED LIABILITY CO. (LLC)      LIMITED LIABILITY PARTNERSHIP (LLP)

Applicant (Name of corporation, partnership, LLC or LLP; if individual, First, Middle, Last):

Trade Name (if any)

Location (include suite no., city, state & zip code)

Mailing Address, if different from location:

FOR OFFICE USE ONLY

Approved \_\_\_\_\_ Initials/date: \_\_\_\_\_

Effective Date: \_\_\_\_\_ License No. \_\_\_\_\_  
PHY - \_\_\_\_\_

Phone No. (Business): ( )      Fax No.: ( )      E-Mail Address: \_\_\_\_\_      Website Address: \_\_\_\_\_

Name of full-time Pharmacist-in-Charge of prescription area:	License No. PH - _____	Check the type of application being made:  <input type="checkbox"/> NEW LICENSE. Business <b>NOT</b> owned by anyone else before. <input type="checkbox"/> NEW LICENSE. Business formerly owned by someone else. (Attach letter of sale) <input type="checkbox"/> <b>RELOCATION</b> . Same owner but in a different location.  License No: PHY - _____
Names of other registered pharmacist employees: (Attach additional sheets if necessary)	License No.	
1. _____ 2. _____	PH - _____ PH - _____	
Name of Manager of store in which prescription area is located	Phone No. ( )	

	Name	Social Security No.	Residence Address	Phone No.
RESIDENCE ADDRESSES	Sole Owner			
	President, Manager or Partner			
	Vice-President, Manager or Partner			
	Secretary, Manager or Partner			
	Treasurer, Manager or Partner			

**The following questions pertain to the applicant and any persons (pharmacists, officers, directors, managers, partners, etc.) responsible for the distribution of drugs:**

- 1) In the past 20 years, have you ever been convicted of a crime related to the pharmacy profession? ..... YES NO
- 2) Are you a U.S. citizen, a U.S. National, or alien authorized to work in the United States? ..... YES NO
- 3) Has any license ever been disciplined (including suspension, revocation or fine) in another jurisdiction, including by a Federal or State regulatory body? ..... YES NO
- 4) Have you ever been in violation of any State or Federal drug, controlled substance, or poison law? ..... YES NO

**List and explain all "YES" answers on a separate sheet and attach copies of court documents or the board's documents relating to these matters.**

**Affidavit of Applicant:**

I certify that the statements, answers and representations made in this application and the documents attached are true and correct. I understand that any misrepresentation is grounds for refusal or subsequent revocation of license and is a misdemeanor (*Section 710-1017, Sections 436B-19 and 461-21, Hawaii Revised Statutes*).

Further, I agree that the pharmacy for which the permit is sought is or will be in full compliance with all state drug, narcotic and poison laws, and Chapter 461, Hawaii Revised Statutes, and Title 16, Chapter 95, Hawaii Administrative Rules.

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Applicant

\_\_\_\_\_ Print Name

\_\_\_\_\_ Title

This material can be made available for individuals with special needs.  
Please call the Licensing Branch Manager at (808) 586-3000 to submit your request.

App..... 496..... \$100	½ Ren..... 490..... \$75
Lic..... 499..... \$ 50	Service Charge..... BCF..... \$25
CRF..... 497..... \$ 35/70	

**BOARD OF PHARMACY**  
Department of Commerce and Consumer Affairs  
Professional and Vocational Licensing Division  
335 Merchant St., P.O. Box 3469  
Honolulu, HI 96801  
Access this form via website at: [www.hawaii.gov/dcca/areas/pvl](http://www.hawaii.gov/dcca/areas/pvl)

**PHARMACY SELF-INSPECTION REPORT**

Date of Inspection: \_\_\_\_\_ Store Name: \_\_\_\_\_  
Pharmacy Name: \_\_\_\_\_ Store Address: \_\_\_\_\_  
Pharmacy Address: \_\_\_\_\_ Store Manager: \_\_\_\_\_  
Pharmacy Hours: \_\_\_\_\_ Phone No: \_\_\_\_\_

\*\*\*\*\*

Pharmacy Permit Displayed? ..... [ ] YES [ ] NO

R. Ph. In Charge: \_\_\_\_\_

License No.: \_\_\_\_\_

License Displayed? ..... [ ] YES [ ] NO

Expiration Date: \_\_\_\_\_

R. Ph on Duty: \_\_\_\_\_

License No.: \_\_\_\_\_

License Displayed? ..... [ ] YES [ ] NO

Expiration Date: \_\_\_\_\_

Pharmacy Intern: \_\_\_\_\_

Permit No.: \_\_\_\_\_

(Attach additional sheets as needed)

Attach Pharmacy Label Here

**PRESCRIPTION AREA**

**REFERENCE LIBRARY**

Federal DEA Regulations ..... [ ] YES [ ] NO  
State Uniform Controlled Substances Law, HRS, Chapter 329..... [ ] YES [ ] NO  
State Food & Drug Laws, HRS, Chapter 328 ..... [ ] YES [ ] NO  
State Pharmacy Law, HRS, Chapter 461 ..... [ ] YES [ ] NO  
State Pharmacy Rules, HAR, Chapter 16-95 ..... [ ] YES [ ] NO  
Prescription Files (5 years) ..... [ ] YES [ ] NO

**TECHNICAL EQUIPMENT**

Graduates or other similar measuring device ..... [ ] YES [ ] NO  
Mortar & Pestal (glass or porcelain) ..... [ ] YES [ ] NO  
Bottles & Vials (assorted) ..... [ ] YES [ ] NO  
Prescription Labels ..... [ ] YES [ ] NO  
Rx Balance (Class A) or a balance of greater sensitivity and appropriate weights..... [ ] YES [ ] NO

PRESCRIPTION AREA (Cont'd)

Name of Pharmacy: \_\_\_\_\_

- 1. Is pharmacy area adequately secured? ..... [ ] YES [ ] NO
- 2. Description and photographs of security system is attached? ..... [ ] YES [ ] NO
- 3. Is there a locked cabinet or is a description of how controlled substances  
are to be secured attached? ..... [ ] YES [ ] NO
- 4. Adequate counters, tables, drawers, shelves and storage cabinets? ..... [ ] YES [ ] NO
- 5. Hot and cold water sink? ..... [ ] YES [ ] NO
- 6. Proper sewage outlet? ..... [ ] YES [ ] NO
- 7. Refrigeration storage equipment? ..... [ ] YES [ ] NO

Comments on any of the above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I understand the Board reserves the right to verify this statement by a subsequent inspection. I further understand that a pharmacy license number will not be assigned until all deficiencies have been corrected. I shall submit a written statement to the Board of Pharmacy to attest that any deficiency has been corrected.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Responsible Pharmacist-in-Charge

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Store Manager

**SECURITY OF PHARMACY PRESCRIPTION AREA**

\_\_\_\_\_  
Name of Pharmacy

Hawaii Administrative Rules, section 16-95-80, Physical Presence of a Registered Pharmacist, requires the following:

- a) A pharmacist must be physically present during the hours of operation of a prescription area, and
- b) At any time a registered pharmacist is not in the prescription area, the entire stock of prescription drugs shall be secured from access to unauthorized persons and the means of access shall only be in the possession of the pharmacist.

I/we the undersigned, acknowledge and understand the foregoing provision.

\_\_\_\_\_  
Signature of applicant or  
company representative

\_\_\_\_\_  
Signature of pharmacist-in-charge

\_\_\_\_\_  
Print name of person signing

\_\_\_\_\_  
Print name of pharmacist-in-charge

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Pharmacy

\_\_\_\_\_  
Address of Pharmacy

**PROVIDE A WRITTEN DESCRIPTION OF SECURITY SYSTEM OF PHARMACY  
AND PRESCRIPTION AREA BELOW**

(Attach additional sheets if necessary)