Application for a Virgin Islands Pharmacy License

Virgin Islands Board of Pharmacy

Type or clearly print (all blanks must be completed - if not applicable, enter N/A)

VI BOP USE ONLY

Application fees are non-refundable. Applications are valid for 1 year from the date of receipt of the ORIGINAL application
The ORIGINAL completed application, ORIGINAL supplemental forms all required attachments shall be mailed to:
Virgin Islands Dept of Health, Office of Professional Licensure, P.O. Box 222995, Christiansted, VI 00822
The required fees must accompany the application. Make check payable to " Government of the Virgin Islands"

IMPORTANT: once the review of the application begins for new pharmacies, the application will be CANCELLED if there is:
Change in Ownership
Change in Managing Officer (i.e.. Additional and/or removal of an officer, or a
Change in Location for the pharmacy

If this occurs, then the applicant must reapply for the license by submitting a new application packet and fee to the Board.

Name of Pharmacy: _____

Type of Application and Fees

(Check Appropriate Box)

☐ **New Pharmacy ($575)**

☐ **Change of Ownership ($180)**
Effective date of Change
_____
Previous Legal Name (Corp. LLC, etc.)
_____
Previous Pharmacy Name
_____
Previous Physical Address
_____
Previous Mailing Address
_____

☐ **Change in Pharmacy Name (No Fee)**
Effective date of Change
_____
Previous Name
_____

☐ **Remodeling of Prescription Department ($350)**

☐ **Change in Pharmacist-in-Charge ($180)**
Effective date of Change
_____
Name of Previous Pharmacist-in-Charge
_____

☐ **Change in Location ($350)**
Previous Location
_____

☐ **Reinstatement due to Lapse of Permit (call Board)**

☐ **Reinstatement due to Suspension or Revocation of Permit (call Board)**

If this application is for a New Pharmacy, Change in Location, or the Remodeling of Prescription Department, what is the anticipated date of opening? _____

Inspections are required for the following applications: New Pharmacy, Change in Location, and Remodeling of Prescription

A minimum of 20 business days is required for scheduling an inspection.

No drugs may be stocked prior to inspection and approval.

The responsible person shall review pharmacy checklist to ensure the readiness of the pharmacy for inspection. The inspector will contact the responsible person prior to the requested inspection date to confirm readiness. If the inspector does not contact the responsible person at least 2 business days before the scheduled inspection, the responsible person shall contact the Board's office at (340) 774-7477 Ext 5694 on St. Thomas or (340) 718-1311 Ext 3849 on St. Croix.

Pharmacy Information

Contact Information

Legal Name (Corp. LLC, etc.)

Pharmacy Name

Physical Address

Street Address

City State Zip Code

Mailing Address

Street Address

City State Zip Code

Pharmacy Phone Number

Pharmacy Fax Number

Federal Employment Identification Number (FEIN)

DEA Registration Number

Web Address

Email Address

Type of Ownership

- ☐ Corporation
- ☐ Limited Liability Company (LLC)
- ☐ Individual/ Sole Proprietorship
- ☐ Partnership
- ☐ Other (specify): _____

Type of Pharmacy

- ☐ Community - Independent
- ☐ Hospital / Institutional
- ☐ Community - Multi/Chain
- ☐ Other (specify) _____

Description of Services - Check All That Apply - Must Indicate at Least 1 Type of Service

- ☐ 24 Hour Service
- ☐ Closed Door
- ☐ Compounding Sterile, LOW Risk
- ☐ Compounding Sterile, MED Risk
- ☐ Compounding Sterile, HIGH Risk
- ☐ Inpatient Prescriptions
- ☐ Outpatient Prescriptions
- ☐ 503B Outsourcing Facility
- ☐ Pharmacist Administered Immunizations
- ☐ Compounding, Non-Sterile*
- ☐ Compounding, Office Use
- ☐ Home Delivery
- ☐ Infusion
- ☐ Shipping Prescriptions / Mail Order
- ☐ Veterinary Prescriptions
- ☐ Nuclear

Other *(specify):*_____

_____

** Do not check this service if the pharmacy is only reconstituting a manufacturer's NON-STERILE product (e.g., reconstituting an antibiotic suspension)*

Pharmacy Hours of Operation

*(*circle appropriate)*

	Open		Close
Sunday	_____ am / pm*	to	_____ am / pm*
Monday	_____ am / pm*	to	_____ am / pm*
Tuesday	_____ am / pm*	to	_____ am / pm*
Wednesday	_____ am / pm*	to	_____ am / pm*
Thursday	_____ am / pm*	to	_____ am / pm*
Friday	_____ am / pm*	to	_____ am / pm*
Saturday	_____ am / pm*	to	_____ am / pm*

Staffing Pharmacists

Name	License #

Name	License #

Certified Technicians

Name	License #

Name	License #

Pharmacist-in-Charge **VI License #**

☐ Check here if PIC is licensed to practice in any other state or territory?

List all other states/territories

By my signature, I acknowledge I am the pharmacist-in-charge of this pharmacy and attest that have read and understand the laws and rules related to this pharmacy.

_____ _____ _____

Print Name of Pharmacist-in-Charge Signature of Pharmacist-in-Charge Date

Statement of Notary Public

Subscribed and sworn before me this _____ day of _____, 20 _____

Notary Public_____ Seal Here

My commission expires: _____

THE OWNER OR ONE OF THE MANAGING OFFICERS MUST ANSWER THE FOLLOWING QUESTIONS:

1	Has the pharmacy or the corporation, partnership or other entity that owns the pharmacy been the subject of ANY professional disciplinary action or are any such actions pending against this entity by a regulatory authority? (e.g., surrender, revocation, reinstatement, suspension, fine, probation, restriction.) Include such Information for all states and territories, and for all regulated professions.	Yes	No
2	Has the pharmacy or the corporation, partnership, or other entity that owns the pharmacy been subject to court ordered probation as related to any offense?	Yes	No
3	If you answered "YES" to question 1 and/or question2, include the name of the Board, licensing or disciplinary authority, and the date of the order, and, if applicable, the date of the termination of the conditions and/or probation:		
4	Does this pharmacy participate in the Medicaid Program?	Yes	No

I hereby attest that the foregoing statements on this form or those on any attachment(s) to this form are to the best of my knowledge true and correct and that they are all given of my free will. I agree that any misstatement(s) or omission(s) as to material facts will constitute violation of and subject me to the penalties set forth in the Virgin Islands Pharmacy Act and Rules. I agree to comply with the Virgin Islands Pharmacy Act and Rules

Print Name Owner/Managing Officer

Signature of Owner/ Managing Officer
THIS SIGNATURE MUST BE NOTARIZED

Date

Statement of Notary Public

Subscribed and sworn before me this _____ day of _____, 20 _____

Seal Here

Notary Public_____

My commission expires: _____