



South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Pharmacy
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FEDERALLY QUALIFIED HEALTH CENTER DRUG OUTLET PERMIT APPLICATION REQUIREMENTS AND INSTRUCTIONS

This permit authorizes a Federally Qualified Health Center (FQHC) Delivery Site to store and administer legend drugs.

S.C. Code Ann. § 40-43-70(A)(3) defines a “health center delivery site” as a physical location where a licensed practitioner duly employed by or under contract with an FQHC provides primary and preventative health care services to patients of that FQHC. An FQHC may have multiple health center delivery sites.

All facilities will be inspected before a permit is issued.

A South Carolina Federally Qualified Health Center Drug Outlet Permit Application has a one-year expiration. Failure to complete all required fields and/or provide necessary supplemental documentation will delay the application process. If an item is not applicable, please indicate N/A. **Items should be provided in the order listed below. Please do not send in binders, folders or use dividers. Ensure all documentation/information is legible, and retain copies of all documents for your records.**

Pursuant to S.C. Code Ann. § 40-43-90(A)(1), an application must be received in the Board office at least **forty-five (45)** days before the required permit is needed to allow for application processing, on-site inspection and, if necessary, written corrective action response.

Using a false, fraudulent or forged statement or document, or committing a fraudulent, deceitful or dishonest act or omitting a material fact in obtaining licensure is grounds for discipline or licensure denial.

A FQHC Drug Outlet Permit requires a **Consultant Pharmacist**.

Include with your application (check N/A if not applicable):

Included N/A

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Check or money order only (no cash) in the amount of \$280 made payable to SC Board of Pharmacy. (Application fee is non-refundable. A returned check fee of up to \$30, or an amount specified by law, may be assessed on all returned funds.) |
| <input type="checkbox"/> | <input type="checkbox"/> | Letter describing, in detail, the nature of your business |
| <input type="checkbox"/> | <input type="checkbox"/> | Policies and procedures relating to the handling of medications and/or legend devices |
| <input type="checkbox"/> | <input type="checkbox"/> | Include organizational chart from the ultimate parent company down to and including the applicant |
| <input type="checkbox"/> | <input type="checkbox"/> | If a change in ownership, include organization charts of before and after the change. Chart must include name of owners with a 10% or greater ownership interest if a non-publicly traded company. |
| <input type="checkbox"/> | <input type="checkbox"/> | Photographs of: <ul style="list-style-type: none">○ Entrance○ Exit○ Product area |

Mail completed application with all above enclosures to the address listed at the top of this page.



FEDERALLY QUALIFIED HEALTH CENTER DRUG OUTLET PERMIT APPLICATION

- New Facility
- Change to Existing Permit (Permit No.: _____)
 - Change of Name
 - Change of Location (from one city to another)
 - Change of Ownership (include organizational chart before and after change)

FOR BOARD USE ONLY	
Date Paid	
Amount Paid	
Check No.	
Inspector	

FACILITY INFORMATION

Federal Tax ID No.: _____ NABP e-Profile ID No. (if applicable): _____
 Legal Name of Facility: _____
 DBA Name: _____
 Facility Address: _____
 City: _____ County: _____ Zip: _____
 Telephone No.: _____ Fax No.: _____
 Expected Opening Date: _____ Days and Hours Open: _____
 Name of pharmacy supplying medication: _____
 Pharmacy Address: _____

Is application based on a change in ownership? Yes No
 If Yes: _____ SC Permit No.: _____
 Previous Name of Facility

Mailing Address where all correspondence regarding permitting will be sent if other than facility above:

Contact Person: _____ Email: _____
 Mailing Address: _____ City: _____ State: __ Zip: _____

OWNERSHIP

Sole Proprietorship Name of Business Entity: _____

Name	City, State	Birth Year

General Partnership **LLP** Name of Partnership/LLP: _____

Partner Name	City, State	Birth Year	% of Ownership

Corporation LLC Legal Name of Corporation/LLC: _____

Is this facility publicly traded? Yes No

Name of Parent Company: _____ State of Incorporation: _____

Name of Individual Owners and Principal Officers	Title	City, State	Birth Year	% of Ownership
1.				
2.				
3.				

Pursuant to S.C. Code Ann. § 40-43-83(E), the board may enter into agreements with other states or with third parties for the purpose of exchanging information concerning the permitting and inspection of entities located in this jurisdiction and those located outside this state.

DISCIPLINARY HISTORY

If you answer “Yes” to any part of this section, provide a detailed explanation on a separate sheet and attach copies of applicable court documentation. Include the city and state where the offense(s) occurred.

TO THE BEST OF YOUR KNOWLEDGE HAS THE APPLICANT, the entity, undersigned permit holder, any person or entity identified in the ownership/management section above, or any entity under common control with the applicant ever:

1. Had any license or permit held by the applicant, permit holder, or by any owner or corporate officer, ever been disciplined, denied, refused, voluntarily surrendered, agreed to permanently cease operations or revoked for violations of any federal or state pharmacy laws or drug laws regardless of state? Yes No

If yes, attach a full written explanation and attach copies of applicable court documentation.

Is there any pending disciplinary action? Yes No

2. Been convicted, fined or entered in a plea of guilty or nolo contendere in any criminal prosecution, felony or misdemeanor in South Carolina or any other state, or in a United States court for:
- a. any offense relating to drugs, narcotics, controlled substances or alcohol, whether or not a sentence was imposed? Yes No
 - b. any offense involving the practice of pharmacy, or relating to acts committed within a pharmacy or drug/device manufacturer setting or incident to pharmacy practice, whether or not a sentence was imposed? Yes No
 - c. any offense involving fraud or dishonesty, whether or not a sentence was imposed? Yes No

ATTESTATION

I hereby certify that the Federally Qualified Health Center Drug Outlet for which this permit is sought will be conducted in full compliance with federal law and the South Carolina Pharmacy Practice Act and the regulations promulgated thereunder and that the drug outlet will be under the supervision of a licensed pharmacist as required by law.

Permit Holder Signature

Date

Print Name of Permit Holder

Title

Email Address of Permit Holder

Phone Number

ATTESTATION

I hereby certify that, as the Consultant Pharmacist, I will be responsible for all duties connected with the proper and lawful conduct of this facility as required by federal law and the South Carolina Pharmacy Practice Act and the regulations promulgated thereunder.

Consultant Pharmacist

Date

Print Name of Consultant Pharmacist

Title

Email Address of Consultant Pharmacist

Phone Number

License Number

PRIVACY NOTICE

South Carolina law requires the agency to collect personal information which is only disseminated as required by law. The South Carolina Freedom of Information Act ensures that the public has a right to access appropriate records and information possessed by a government agency. Therefore, some personal information on your renewal application and other documents on file may be subject to public scrutiny or release. The Department collects and disseminates personal information in compliance with The South Carolina Freedom of Information Act, the South Carolina Family Privacy Protection Act and other applicable privacy laws and regulations. Additionally, the Department shares certain information on the application with other governmental agencies for various governmental purposes, including research and statistical purposes.