



South Carolina Department of Labor, Licensing and Regulation

**South Carolina Board of Pharmacy**

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[llr.sc.gov/bop](http://llr.sc.gov/bop)

**HEALTH SYSTEM NON-DISPENSING DRUG OUTLET PERMIT APPLICATION  
REQUIREMENTS AND INSTRUCTIONS**

**This permit authorizes a Hospital Owned Health System, which stores and administers legend drugs and or devices, to operate multiple facilities covered under a single associated hospital Pharmacy Permit that has already been issued by the Board.** A South Carolina Health System Non-Dispensing Drug Outlet (“HSNDDO”) Permit Application is valid for one (1) year.

A Hospital Owned Health System Non-Dispensing Drug Outlet Permit requires that the **Pharmacist-in-Charge** of the associated hospital pharmacy be responsible for all facilities that fall under the HSNDDO Permit.

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.**

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

**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 \$280.00 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"/> | Copies of policies and procedures relating to the handling of medications and/or legend devices  |
| <input type="checkbox"/> | <input type="checkbox"/> | List of each facility covered by the Hospital Non-Dispensing Drug Outlet Permit (name, address and phone number)   |
| <input type="checkbox"/> | <input type="checkbox"/> | If this application includes a change of ownership, include organizational charts of before and after the change. Charts must include names of owners with a 10% or greater ownership interest if a non-publicly traded company.                   |

Mail application, required documentation and payment to the address listed at the top of this page.



**HEALTH SYSTEM NON-DISPENSING DRUG OUTLET PERMIT APPLICATION**

**FACILITY INFORMATION FOR ASSOCIATED HEALTH SYSTEM PHARMACY PERMIT**

FOR BOARD USE ONLY	
Date Paid	
Amount Paid	
Check Number	
Inspector	

Federal Tax ID No.: \_\_\_\_\_

NABP e-Profile ID No. (if applicable): \_\_\_\_\_

Name of Hospital: \_\_\_\_\_ Hospital Pharmacy Permit No.: \_\_\_\_\_

Legal Name of Associated Pharmacy: \_\_\_\_\_

DBA Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

County in which facility is located: \_\_\_\_\_

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

Contact Person: \_\_\_\_\_ Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_ Zip: \_\_\_\_\_

Pursuant to S.C. Code Ann. Section § 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.

List of clinics/practices covered by this Hospital System Non-Dispensing Drug Outlet Permit. If additional space is needed, list all sites on a separate sheet.

Name	Address	Phone Number

