South Carolina Department of Labor, Licensing and Regulation
South Carolina Board of Pharmacy
110 Centerview Dr. • Columbia • SC • 29210
P.O. Box 11927 • Columbia • SC 29211-1927
Phone: 803-896-4700 • Contact.pharmacy@llr.sc.gov • Fax: 803-896-4596
llr.sc.gov/bop

NON-RESIDENT NON-DISPENSING PHARMACY PERMIT APPLICATION INSTRUCTIONS

A Non-Resident Non-Dispensing Pharmacy Permit is required for a facility engaged in the provision of pharmacy care, other than the dispensing of drugs or devices, to patients in South Carolina.

The pharmacist-in-charge for the applicant must be a S.C. licensed pharmacist. The facility must be in compliance with S.C. Board of Pharmacy Policy and Procedure #147.

The pharmacist-in-charge for the applicant must attend an Application Review Committee meeting at the Board's office. Applicant will be notified by e-mail of the date and time of the meeting for which they are scheduled. All requested information and emailed confirmation are required prior to the meeting date. Using false, fraudulent, 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 Non-Resident Non-Dispensing Pharmacy Permit 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.

Submit the completed application and the following:

- Application fee in the form of a check or money order (no cash) in the amount of **$420** made payable to SC Board of Pharmacy
  (The 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.)
- Copy of resident state pharmacy permit
- List of state pharmacy permits/licenses held in other states with expiration date
- Copy of recent inspectionreport.
- Inspection must have been conducted within the last 2 years.
- Letter describing, in detail, the nature of your business
- Photographs:
  - exterior of pharmacy building to include identifiable parts of adjacent buildings
  - work area
- Certification statement: No prescription drugs purchased, stored or distributed
- Include organizational chart before and after change (Change of Ownership)

Mail completed application and required documents to either:

MAILING ADDRESS:

SC BOARD OF PHARMACY
PO BOX 11927
COLUMBIA SC 29211-1927

OVERNIGHT/STREET ADDRESS:

SC BOARD OF PHARMACY
110 CENTERVIEW DR SUITE 201
COLUMBIA SC 29210

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NON-RESIDENT NON-DISPENSING PHARMACY

☐ 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.	

Federal Tax ID No.:_____ Resident State License No.:_____

Name of Pharmacy: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email:_____

Mailing address where all correspondence regarding licensure will be mailed if other than facility above:

Contact Person: _____ Email:_____

Facility Name: _____

Facility Address: _____

City: _____ State: _____ Zip: _____

PHARMACY INFORMATION

Pharmacist-in-Charge:_____ S.C. Pharmacist License No.:_____

Email:_____

*****Attach a list of pharmacists and technicians employed at this location indicating name, license type, license number and employment status.***

2. Pharmacy website address: _____

3. Hours of operation:_____ Hours a pharmacist is available:_____

4. When was your last Board of Pharmacy inspection?_____
(Attach a copy of the inspection report)

5. Indicate the primary type of service at this location:

☐ Data entry for retail ☐ Data entry for hospitals ☐ Date entry for long term care
☐ Call Center ☐ Medication therapy management ☐ Consulting Only

6. Date your pharmacy began providing these services to South Carolina patients:_____

7. Approximate number of South Carolina patients served annually:_____

OWNERSHIP

Check appropriate box and provide complete information.

☐ Sole Proprietorship Name of Business Entity: _____

Name	City, State	Birth Year	% of Ownership

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

Partner Name	City, State	Birth Year	% of Ownership

☐ General Corporation ☐ LLC Name of Corporation/LLC: _____

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

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 a permit disciplined, denied, refused or revoked for violations of any pharmacy laws or drug laws in South Carolina or any other state? ☐ YES ☐ NO
   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 distributor setting or incident to pharmacy practice, whether or not a sentence was imposed? ☐ YES ☐ NO

   c. any offense involving fraud, dishonesty or moral turpitude whether or not a sentence was imposed? ☐ YES ☐ NO

3. Had an application for a drug/device distributor permit, pharmacy, or pharmacist license, permit or certificate or a technician license or registration, denied, refused in South Carolina or any other state or country? ☐ YES ☐ NO

4. Had disciplinary action taken against you, or a pharmacy or drug distributor facility you owned, or a pharmacy or drug/device distributor facility where you were employed, by the Board of Pharmacy (or its equivalent) in South Carolina or any other state or country? ☐ YES ☐ NO

5. Operated, or allowed the facility to operate without a valid permit? ☐ YES ☐ NO

6. Violated the drugs/device laws, rules, statues and/or regulations of South Carolina, or any other State or Country or the United States? ☐ YES ☐ NO

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.

ATTESTION

I declare that I have read and approve the foregoing and the statements are true and correct to the best of my knowledge and belief; I will comply with the Code of Laws of the South Carolina Pharmacy Practice Act and I understand I am responsible for any violation occurring during my tenure.

Pharmacist-In-Charge Signature _____ Date _____

Print Name of Pharmacist-In-Charge _____ Title _____ SC License No. _____

Email Address of Pharmacist-In-Charge _____ Phone No. _____

I declare that foregoing statements are true and correct to the best of my knowledge and belief; the permit applied for is to cover only the pharmacy indicated above and the location specified; and that I will comply with the Code of Laws of the South Carolina Pharmacy Practice Act.

Permit Holder Signature _____ Date _____

Print Name of Permit Holder _____ Title _____

Email Address of Permit Holder _____ Phone No. _____

CERTIFICATION STATEMENT

This statement to be completed by the Pharmacist-in-Charge of the Non-resident Non- dispensing Pharmacy permit as a consulting, remote order entry, or medication therapy management pharmacy only.

I certify that no prescription drugs are to be purchased/acquired, stored, used or distributed at this location.

Name of pharmacy:_____

Street address: _____

City:_____State_____Zip code _____

Printed name of Pharmacist-in-charge:_____

Signature of Pharmacist-in-charge: _____

Sworn to and signed before me this date:

Date:_____

Signature of Notary:_____

For the state of: _____

My commission expires: _____