Arkansas State Board of Pharmacy
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John Clay Kirtley, Pharm.D., Executive Director

Application for a Permit to Operate as a Charitable Clinic in Arkansas

PART I: GENERAL INFORMATION

Clinic Name:

Employer Identification Number:

Physical Address of Applicant:

Street:

City: State: Zip:

Telephone Number: Fax Number:

Website:

Mailing Address:
(Complete this section ONLY if different from the physical address above.)

Street or PO Box:

City: State: Zip:

Person with whom the Board of Pharmacy may communicate regarding this application:

Name: Position:

Telephone: Email:

Type of Charitable Clinic:

☐ Clinic of the Arkansas Department of Health ☐ Other Charitable Clinic

Individual or Group Responsible for the Clinic:

Hours of Operation:

(Check all that apply):				Day	Hours (Express in terms of a.m. and p.m.)	Total Hours / Day
☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	Sunday		
☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	Monday		
☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	Tuesday		
☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	Wednesday		
☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	Thursday		
☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	Friday		
☐ 1st	☐ 2nd	☐ 3rd	☐ 4th	Saturday		
					Total Number of Hours Per Week:	

FOR OFFICE USE ONLY:

License Number: _____ Date Issued: _____

PART II: PERSONNEL

List all individuals filling prescriptions or performing any function considered to be the practice of pharmacy for this facility. You may attach additional sheets if needed. **YOU MUST NAME A PHARMACIST IN CHARGE.**

Name	License #	Hours/Week	Degree
Pharmacist in Charge:			
Other Pharmacists:			
Pharmacy Technicians:			

PART III. OPERATIONS

Please respond to the following statements/questions. You can attach a separate sheet if you need more space.

Please provide a general description of the medications and products that you plan to dispense. You may attach a separate sheet if necessary.
Do you plan to charge clinic patients any type of fee, or ask for donations? ☐ YES ☐ NO If **Yes**, please explain.
Describe in detail how the pharmacy will comply with regulation 09-00-0001 – patient counseling, patient profile, drug use evaluation.
How will your pharmacy and the pharmacist in charge ensure that patient confidentiality is maintained?
Describe the computer hardware and software that will be used in the pharmacy.

How does your pharmacy ensure a valid patient / physician relationship?
Do you process prescriptions for insurance companies and PBMs? ☐ YES ☐ NO If **Yes**, please name those companies.
Are you are involved in any aspect of telemedicine? ☐ YES ☐ NO If **Yes**, please describe.

PART IV: DOCUMENTATION

Attach copies of the following documents to this application, or an explanation of why these documents are not included:

A. A copy of the charitable clinic pharmacy's Policies and Procedures. These Policies and Procedures must be approved by the Board.

B. A copy of the floor plan.

C. A copy of the formulary.

D. A copy of the non-profit or organizational certificate, if applicable.

PART V: CERTIFICATION

Please read carefully and sign below.

I swear, or affirm that all statements made herein and on the attached forms are true and correct. All of the provisions of Arkansas laws and regulations related to the practice of pharmacy in Arkansas will be faithfully observed during the period any permit issued may be in force and effect.

I swear and affirm that I know where to locate the statutes and regulations related to the practice of pharmacy in Arkansas. (They are available online at the Arkansas State Board of Pharmacy website in the Pharmacy Lawbook section under the Pharmacy Practice Act § 17-92-101 et seq and Regulations 1 through 12.)

By virtue of filing this application, I do solemnly swear or affirm that I am of good moral character, and that I understand the instructions and terms as set forth in this application form, that I have personally completed this form, that the information given in this application is true, correct and complete to the best of my knowledge. I authorize the Arkansas State Board of Pharmacy to review files pertaining to this application and related documents, and all law enforcement records, administrative records, and court documents to confirm the accuracy and completeness of the information provided herein. This application and signature shall act as authorization for entities in possession of applicable information to release such information to the Arkansas State Board of Pharmacy.

Signature of Pharmacist in Charge: _____

Print the name of the Pharmacist in Charge: _____

Pharmacist License # : _____ Date: _____