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

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. A South Carolina Health System Non-Dispensing Drug Outlet Permit Application is valid for one year.

All facilities will be inspected before a permit is issued.

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

Per S.C. Code Ann. § 40-43-90(A)(1), applications must be received 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.

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	
☐	☐	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.)
☐	☐	A letter describing, in detail, the nature of your business
☐	☐	Copies of policies and procedures relating to the handling of medications and/or legend devices
☐	☐	Provide a list of each facility covered by the Hospital Non-Dispensing Drug Outlet Permit
☐	☐	Provide a list of all pharmacy permits/licenses held in other states
☐	☐	Photographs of: o Entrance o Exit o Product area
☐	☐	Include organizational chart from the ultimate parent company down to and including the applicant entity
☐	☐	If a change of ownership, include organization charts of before and after the change. Chart must include names of owners with a 10% or greater ownership interest if a non-publicly traded company.

Mail application to the address listed at the top of this page.

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HEALTH SYSTEM NON-DISPENSING 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 Number	
Inspector	

FACILITY INFORMATION

Federal Tax ID No.: _____ NABP e-Profile ID No. (if applicable): _____

Legal Name of Facility: _____

DBA Name: _____

Facility Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ Fax No.: _____

County in which facility is located: _____

Expected Opening Date: _____ Days and Hours Open: _____

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: _____

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 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.

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. Has any license or permit held by the applicant, permit holder, pharmacist 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 facility for which this permit is sought will be conducted in full compliance with the statutory laws of this State pertaining to pharmacy 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

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 Regulations promulgated thereunder.

Consultant Pharmacist Signature	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.