



**2026-2027 NON-RESIDENT OUTSOURCING 503B PERMIT RENEWAL**

**Before you renew:**

- South Carolina law requires permit holders to notify the Board within ten (10) working days if there has been a change in ownership, legal name change, change in business form, management, pharmacist responsible for compounding or relocation of the facility. **DO NOT RENEW** if any of these changes have occurred. You must contact the Board before renewing the permit. See S.C. Code § 40-43-91(B)(2).
- **Submit** a copy of the most recent facility inspection report (FDA or state).

<b>FOR BOARD USE ONLY</b>	
Date Paid	
Check No.	
Amount Paid	

**Renewal Requirements and Instructions:**

- To electronically submit this permit renewal directly to the Board visit: <https://eservice.llr.sc.gov/DocumentSubmission/>. The renewal fee may be paid via debit/credit card or electronic check.

**Note:** If mailing the paper application for permit renewal, submit the renewal fee in the form of a check or money order (no cash) payable to SC Board of Pharmacy. (All fees are non-refundable. A returned check fee of up to \$30, or an amount specified by law, may be assessed on all returned funds.)

- **Renewal / Late Fees:**  
 Postmarked on or before May 31, 2026: **\$700**  
 Postmarked on or after June 1, 2026: Late Fee \$50 + Renewal Fee \$700 = **\$750**
- Beginning July 1, 2026, lapsed permits will be assessed fees of \$10/day until the permit is reinstated.
- Permits not renewed by June 30, 2026, are lapsed. A facility that operates with a lapsed permit is in violation of S.C. Code Ann. § 40-43-140 and may be subject to disciplinary action. Additionally, a permit holder who allows a site to operate with a lapsed permit is in violation of S.C. Code Ann. § 40-43-83 and may be subject to disciplinary action.

**FACILITY INFORMATION**

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

SC DPH Controlled Substances Registration No. (if applicable): \_\_\_\_\_

DEA Registration No. (if applicable): \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Resident State License No.: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

NABP e-Profile ID (if applicable): \_\_\_\_\_

Legal Name of Facility: \_\_\_\_\_

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

Facility Address (physical): \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Facility Name: \_\_\_\_\_

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

**Permit Holder Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Email: \_\_\_\_\_

**Responsible Pharmacist at this facility:**

Name: \_\_\_\_\_ State and License No.: \_\_\_\_\_

**FACILITY OPERATIONS**

- 1. Does this facility distribute, store, or manufacture controlled substances?  Yes  No
- 2. Has there been a change in ownership, legal name change, change in business form, or relocation of the facility?  Yes – Contact the Board of Pharmacy office before completing this application.  No
- 3. Has this facility been inspected by the FDA?  Yes  No  
 If yes, was the facility issued a 483?  Yes  No  
 If yes, [submit](#) a copy of the FDA form 483 and the company’s response to the issues noted.
- 4. Which of the following entities do you sell/ship products to? (Check all that apply)  
 Retail Pharmacies     Hospital Pharmacies     Permitted Clinics/Surgery Centers  
 Practitioners (MD, DMD, DVM, APRN, PA-C)     Other: \_\_\_\_\_

**COMPOUNDING**

- 1. Does this facility engage in category 3 compounding of sterile drug products?  Yes  No
- 2. Does this facility engage in category 2 compounding of sterile drug products?  Yes  No
- 3. Does this facility engage in category 1 compounding of sterile drug products?  Yes  No
- 4. Does this facility engage in the compounding of non-sterile drug products?  Yes  No
- 5. Does this facility compound hazardous medication?  Yes  No
- 6. Does this facility dispense compounded drugs pursuant to valid prescriptions in South Carolina?  Yes  No  
 If yes, a separate pharmacy permit is required.  
 S.C. Pharmacy Permit No., if applicable: \_\_\_\_\_  
 Outsourcing facilities sharing the same physical space with a pharmacy must perform all compounding in compliance with cGMPs.
- 7. Have all personnel involved in compounding completed annual continuing education and/or training in the last year?  Yes  No

**DISCIPLINARY HISTORY**

For any “Yes” answers below, please provide and submit a detailed explanation for each person or entity to whom a Yes answer applies. Official documentation of judgment(s) or disposition(s) must also be provided by the applicable person and/or the entity’s authorized agent, as well as the city and state where the offense(s) or discipline occurred.

**To the best of your knowledge, SINCE THE LAST RENEWAL, (or if this is your first renewal since your initial licensure), has the applicant, the entity, undersigned permit holder, responsible pharmacist, any person or entity identified as holding a position in ownership/management, or any entity under common control of the applicant:**

- 1. Had a professional license or permit disciplined, denied, refused, voluntarily surrendered, agreed to permanently cease operations, or revoked?  Yes  No
  - a. Have any pending disciplinary action?  Yes  No

2. Been convicted, fined, or entered in a plea of guilty or nolo contendere to a crime (other than a minor traffic offense)?  Yes  No
- a. Have any legal action pending related to violations of any federal or state pharmacy laws or drug laws regardless of the jurisdiction of legal action?  Yes  No
3. Operated, or allowed any facility to operate, without a valid permit?  Yes  No

**PERMIT HOLDER ATTESTATION**

- I hereby affirm that I have read and approved the forgoing renewal application. I affirm that all information and statements contained herein are true and accurate to the best of my knowledge and belief.
- I accept responsibility to ensure additional explanation and documentation will be provided, if necessary. I further understand that this application will not be processed until all documentation is received.
- I will comply with all federal and state laws related to operations at the above-named facility, and acknowledge responsibility for any violation(s) of law.
- I understand that 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.

\_\_\_\_\_  
Permit Holder Signature

\_\_\_\_\_  
Date

**RESPONSIBLE PHARMACIST ATTESTATION**

- I hereby affirm that I have read and approved the foregoing renewal application. I affirm that all information and statements contained herein are true and accurate, to the best of my knowledge and belief.
- I understand that I am responsible for abiding by the statutes and regulations governing my role as the facility’s pharmacist responsible for compounding.
- I hereby certify that the facility for which this permit renewal is sought will be operated in full compliance with all applicable federal and South Carolina laws including, but not limited to, the storage and shipment of medications pursuant to this permit.
- I affirm responsibility to ensure this facility shall employ adequate personnel with the education and experience necessary to safely and lawfully engage in the practice of pharmacy.
- I understand that 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.

\_\_\_\_\_  
Responsible Pharmacist Signature

\_\_\_\_\_  
Date