

**KERN FAMILY HEALTH CARE
PHARMACY APPLICATION**

NABP: _____ Tax ID #: _____

Pharmacy Name: _____

Address: _____

City: _____ St: _____ Zip: _____

Mailing Address: _____
(If different from store address)

Phone () _____ Fax () _____

E-mail Address: _____

Is this pharmacy conducted as a: Corporation LLP Sole Other

Services Provided:
 Compounding DME Home Infusion Enteral Feeding TPNs Delivery

If delivery service available, is there a prescription minimum: Yes No

Corporation Name: _____
(If applicable)

If subsidiary of another corp., name of parent corp.: _____

Owner Name: _____

Owner Address: _____

Phone () _____ Fax () _____

Number of Years in Operation: _____

Pharmacy Permit #: _____ DEA #: _____

STAFF INFORMATION:

Please list **Pharmacist in Charge** (include a copy of license) and all **staff pharmacists** and **pharmacy technicians** employed by this pharmacy. Include name, license #, and expiration. (Attach additional sheet if necessary)

<u>Full Name</u>	<u>License #</u>	<u>Exp. Date</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Number of Clerks: _____ Bilingual Staff Yes No

SITE INFORMATION:

Date of last State Board of Pharmacy inspection: _____

State Board of Pharmacy Self-Assessment completed and on file: Yes No

Does this pharmacy have?

Return to Stock Policy Yes No every _____ days

Signature Log: Yes No Access for disabled: Yes No

Private consultation area: Yes No Reference Material Available: Yes No

Liability Carrier: _____
(Minimum Professional limits \$1M / \$3M and General limits \$1M)

Medi-Cal Provider: Yes No If Yes, Medi-Cal Provider #: _____

Medi-Care Provider: Yes No If Yes, Medi-Care Provider #: _____

California Children's Services (CCS): Yes No

Does your pharmacy bill secondary insurance for Co-payments? Yes No

List any other available services at this pharmacy: _____

List any health screenings available at this pharmacy: _____

Are you willing to display and provide payer-prepared health education and preventive health promotional flyers to payer's specific patient population apart from other populations you serve?
 Yes No

PHARMACY HOURS:

Monday _____ to _____

Tuesday _____ to _____

Wednesday _____ to _____

Thursday _____ to _____

Friday _____ to _____

Saturday _____ to _____

Sunday _____ to _____

Holidays Yes No

Open 24 hours Yes No

Other: _____

Does your pharmacy provide after-hours emergency prescription services? Yes No

I hereby attest that I have the authority to sign this statement and confirm the information included in this document is correct. I further attest to our compliance with Section 1793.7 of Title 16 Requirements for Pharmacies Employing Pharmacy Technicians at all times. If at anytime, the pharmacy is unable to comply with these requirements, Kern Health Systems Provider Relations Department will be notified immediately.

Signature: _____ Date: _____

Print Name: _____ Title: _____