PRESCRIPTION DRUG REPOSITORY PROGRAM APPLICATION
(HG 15-601 - 609)
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The Maryland Prescription Drug Repository Program (the "Program") was established to allow Maryland Board of Pharmacy (the "Board")- approved repositories and/or drop-off sites to accept donated prescription drugs and medical supplies for the purpose of dispensing the donated drugs to needy individuals.

An Application Must Be Filed:

- To become a repository that accepts and dispenses donated prescription drugs or medical supplies;
- To become a Board-approved drop-off site that accepts donated prescription drugs or medical supplies for transfer to a repository; and/or
- To notify the Board of a change in location or ownership of a pharmacy/health care facility previously approved to be a repository or a drop-off site under the Program.

Eligible Applicants:

- **Repository:**
  The Board will approve an applicant that:

  - Is a Maryland licensed pharmacy in good standing with the Board;
  - Does not have a final disciplinary order issued against it by the Board; and
  - Is not owned or operated by a health care practitioner who has not fulfilled the requirements of a final disciplinary order that may have been issued against the owner or operator by a health occupations board.

- **Drop-off Site:**
  The Board will approve an applicant that:

  - Is a Maryland licensed pharmacy, or health care facility as defined in COMAR 10.34.33.01B(3), that is in good standing with the Board and or the Maryland Office of Health Care Quality (OHCQ);
  - Does not have a final disciplinary order issued against it by a health occupations board;
  - Is not owned or operated by a health care practitioner who has not fulfilled the requirements of a final disciplinary order that may have been issued against the owner or operator by a health occupations board; and
  - Assigns a pharmacist or other health care practitioner the responsibility to accept donated prescription drugs or medical supplies at the drop-off site.
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PRESCRIPTION DRUG REPOSITORY APPLICATION INSTRUCTIONS

Please review all Program requirements under Md. Code Ann., Health General §15-601 – 609, Annotated Code of Maryland and related regulations before completing the Prescription Drug Repository Application. A response or explanation must be provided for all questions. An approval may be delayed if appropriate responses to all questions are not provided.

Submit the completed application, with the required ownership information attached, to:

Maryland Board of Pharmacy, P.O. Box 2051, Baltimore, MD 21203-2024

I. Applicant Information

A. Application Type – Please indicate the services the applicant is seeking to provide in the state. Select one option only.
B. Please provide all requested information about the pharmacy or health care facility where the service will be provided.
C. The legal applicant is the individual that is authorized to respond to questions and make any decision regarding the operation of the pharmacy or health care facility. This individual may or may not be the same person who completes the application.

II. Ownership Description - Attach a list of the owners and corporate officers, for all levels of ownership. Include the following on the attachment: Name, Title, Percent ownership, Business address, Telephone Number, and Fax Number.

A. Indicate the date that the pharmacy/facility initially opened.
B. Indicate the date of the most recent inspection by the Board, Division of Drug Control, Office of Health Care Quality, and/or other health care facility licensing body in Maryland.
C. Attach a detailed explanation about any violations (federal, state or local convictions) as requested.
D. Indicate the type of ownership (select only one). If a corporation, list principal owners, indicate the corporate name, charter state and date of charter, and indicate whether it is a Public or Non-Public corporation.

III. BUSINESS OPERATIONS

A. Indicate all applicable descriptions of the pharmacy.
B. Indicate all applicable descriptions of the health care facility services.
C. If the pharmacy/health care facility conducts business on the internet, describe the services and web site business name(s).
D. Indicate the hours of operation for each day of the week.
E. Personnel - List employees' names who will be accepting and dispensing donated prescription drugs or medical supplies, in addition to their scheduled hours and license/permit numbers and expiration dates. The Board must be notified within 30 days of any changes in pharmacist's/health care practitioner's employment.

IV. CERTIFICATION – Each item must be initialed by the legal applicant.

V. SIGNATURE – The statement must be signed by the legal applicant.

Maryland Board of Pharmacy
4201 Patterson Avenue
Baltimore MD 21215-2299
Phone: 410-764-4755
Fax: 410-358-6207
www.health.maryland.gov/pharmacy

APPLICATION FOR PRESCRIPTION DRUG REPOSITORY (HG 15-601 - 609)

Please refer to instruction for completing the Application. Approval may be delayed if appropriate responses to all questions are not provided.

I. APPLICANT INFORMATION	
Date:	

A. APPLICATION TYPE: CHECK ALL THAT APPLY
☐ **Disposal of Non-CDS and Medical Supplies ONLY**
☐ **Disposal of CDS, Non-CDS, and Medical Supplies**
☐ **Re-dispensing of Donated Prescription Drugs and Medical Supplies to Needy Individuals**

B. APPLICANT FACILITY INFORMATION					
Pharmacy/Health Care Facility Name – Doing Business As (DBA) or Trade Name:					
Current Permit/License Number					
Street Address:					
City:		**State:**		**Zip:**	
Business Telephone #:					
Business Fax #:					
Web Site Address:					
Email Address:					
Federal Tax ID #:					

C. PHARMACY/HEALTH CARE FACILITY CONTACT INFORMATION			
Legal Representative:			
Name:		**Title:**	
Telephone:		**Fax:**	

Person Completing Application			
Name:		**Title:**	
Telephone:		**Fax:**	

II. OWNERSHIP INFORMATION	
A. Date Established:	

B. Date of Last State Inspection:	

C. Has the corporation or any officers thereof, or any partners, or the individual owner ever been convicted of violations of any federal, State, or local laws or regulations dealing with drug products or alcohol?	☐YES ☐ NO (If yes, attach a detailed explanation)

D. OWNERSHIP INFORMATION IS ATTACHED:			☐YES ☐ NO
	Individual Ownership Partnership Corporation		
	Corporate Name:		
	Principal Owner(s):		
	Charter State:	Date:	
	☐Non-Public ☐Public		

III. BUSINESS OPERATIONS		
A. TYPE OF PHARMACY SERVICES		
☐Assisted Living	☐Chain (10 or more stores)	☐Clinic
☐Community (less than 10 stores)	☐Comprehensive Care (Long Term Care)	☐Consultant
☐Correctional Institution	☐Free Clinic	☐HMO
☐Durable Medical Equipment (DME) / Device	☐Home Health	☐Hospital
☐Independent	☐Internet	☐Intravenous Therapy
☐Mail Order	☐Managed Care	☐Nursing Home
☐Non Sterile Compounding	☐Nuclear	☐Veterinary
☐Pharmacy Service Center	☐Research	☐Sterile Compounding
☐Other (please describe):_____		

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B. TYPE OF HEALTH CARE FACILITY SERVICES:		
☐Hospital	☐Long Term Care	☐Home Health
☐Nursing Home	☐Day Care	☐HMO
☐Clinic	☐Free Clinic	☐Managed Care
☐Other (please describe):_____		

C. SERVICES PROVIDED THROUGH THE INTERNET?	☐YES ☐NO
1. Specify Services:	
2. Website Business Name(s):	

D. HOURS OF OPERATION			
Sunday		Thursday	
Monday		Friday	
Tuesday		Saturday	
Wednesday			

E. PERSONNEL

Personnel accepting and dispensing donated prescription drugs or medical supplies:

EMPLOYEE NAME	FULL / PART-TIME	MARYLAND LICENSE / REGISTRATION #	EXPIRATION DATE
	☐F/T ☐P/T		
	☐F/T ☐P/T		
	☐F/T ☐P/T		
	☐F/T ☐P/T		
	☐F/T ☐P/T		
	☐F/T ☐P/T		

IV. CERTIFICATION

Please initial each statement:

☐	**a. I hereby certify that the pharmacy/health care facility is equipped with sanitary appliances such as toilets, plumbing, running water, lighting, etc. in order to maintain the premises in a clean and orderly manner.**
☐	**b. I hereby certify that the pharmacy/health care facility meets the requirements of the attached Code of Maryland Regulations regarding the Prescription Drug Repository Program (COMAR 10.34.33).**
☐	**c. I hereby certify that the pharmacy/health care facility does not have a final disciplinary order issued against it by a health occupations board.**
☐	**d. I hereby certify that the owner or operator of the pharmacy/health care facility has fulfilled any requirements of a final disciplinary order that may have been issued against the owner or operator by a health occupations board.**

V. LEGAL SIGNATURE

By signing this application, I solemnly affirm under the penalties of perjury that the contents of this application are true to the best of my knowledge, information, and belief. I understand that the repository registration issued pursuant to this application may be revoked if any statement made in this application is found to be false.

Signature of Legal Applicant:	
Name and Title:	
Business Telephone #:	
Business Fax #:	
Email Address:	