

Wyoming State Board of Pharmacy  
1712 Carey Avenue, Suite 200  
Cheyenne, WY 82002  
Phone: (307) 634-9636 Fax: (307) 634-6335  
Email: BOP@wyo.gov

**NON-RESIDENT PHARMACY APPLICATION**

Application Fee: \$300.00  
Controlled Substance Registration Fee: \$40.00 (if you will dispense controlled substances to Wyoming residents)

- Make check payable to the Wyoming State Board of Pharmacy.
- License will expire on June 30<sup>th</sup> of each year.
- Renewal notices will be mailed in April of each year. Renewal fees will be the same as the application fees.

Complete the following. If space is not adequate, use an attachment. Incomplete applications will be returned, delaying your licensure in Wyoming.

Name of Pharmacy (DBA): \_\_\_\_\_  
Name of Business (if different than above): \_\_\_\_\_  
Physical Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Mailing Address (if different than above): \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Website: \_\_\_\_\_

Type of Ownership:  Individual  Partnership  Corporation  L.L.C.

Pharmacy performs compounding? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes: Sterile \_\_\_\_\_ Non—Sterile \_\_\_\_\_

FEIN Number (Federal Employer Identification Number) \_\_\_\_\_

Names of Owners:  
Provide names and addresses of owner(s), if individual or partnership; names of each corporate officer or director, if a corporation; or names of members, if a limited liability company (you may attach a list):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Pharmacist-In-Charge:**

_____	_____	Full-Time <input type="checkbox"/>	Part-Time <input type="checkbox"/>
Name	License Number and State		

**Staff Pharmacists (you may attach a list):**

_____	_____	Full-Time <input type="checkbox"/>	Part-Time <input type="checkbox"/>
Name	License Number and State		
_____	_____	Full-Time <input type="checkbox"/>	Part-Time <input type="checkbox"/>
Name	License Number and State		
_____	_____	Full-Time <input type="checkbox"/>	Part-Time <input type="checkbox"/>
Name	License Number and State		
_____	_____	Full-Time <input type="checkbox"/>	Part-Time <input type="checkbox"/>
Name	License Number and State		

Pharmacy Hours: \_\_\_\_\_

Method of counseling utilized for new prescriptions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Complete and provide copies of the following:**

Federal DEA Registration Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

State Pharmacy License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Date of most recent pharmacy inspection by the licensing Board in your State: \_\_\_\_\_

**WYOMING CONTROLLED SUBSTANCE REGISTRATION**

The Wyoming Controlled Substance Act, 1971, requires the registration of all pharmacies that dispense controlled substances to residents of Wyoming. **Check the appropriate box and include the registration fee of \$40.00, if you will dispense controlled substances to residents in Wyoming.**

Will dispense controlled substances to residents in Wyoming, including controlled substance prescriptions in the following schedules (*check all applicable schedules*):

II

III

IV

V

Will not dispense controlled substances to residents in Wyoming.

**THE FOLLOWING QUESTIONS MUST BE ANSWERED**

1. Has the applicant, or (a) any of applicant's partners if applicant is a partnership; or (b) any of applicant's corporate officers or directors, if the applicant is a corporation; or (c) any members, if the applicant is a limited liability company; or (d) any of the applicant's employees with access to controlled substances, been convicted of any violation of state or federal law relating to the possession, dispensing, delivery, or distribution of controlled substances or prescription drugs, or are any such criminal charges currently pending?

Yes (*provide specifics on a separate attachment*)  No

2. Has the applicant, or (a) any of applicant's partners if applicant is a partnership; or (b) any of applicant's corporate officers or directors, if the applicant is a corporation; or (c) any members, if the applicant is a limited liability company had any previous pharmacy license or registration surrendered, revoked, suspended, denied, or is such an action pending?

Yes (*provide specifics on a separate attachment*)  No

3. Is this application for licensure submitted as a result of "change in ownership"?

Yes

No

If Yes, indicate current license holder's pharmacy name: \_\_\_\_\_

and Wyoming license number: \_\_\_\_\_

and the effective date of this "change in ownership": \_\_\_\_\_

**The Wyoming State Board of Pharmacy must be notified in writing when any of the following occur:**

1. Whenever there is a change in pharmacist-in-charge (PIC), the Board must be notified within seven (7) days of change.
2. Whenever there is a change in physical address of the pharmacy, 30 days prior to the change.
3. Whenever there is a change in name of the pharmacy.
4. Whenever there is a change in ownership. Change of ownership requires reapplication and payment of license fee, 21 days prior to the change of ownership.

**Wyoming Law:**

The Wyoming Pharmacy Act, the Wyoming Controlled Substances Act, the Wyoming Pharmacy Act Rules and Regulations, and the Wyoming Controlled Substances Act Rules and Regulations can be downloaded from our website:

<http://pharmacyboard.state.wy.us>

I hereby apply for a pharmacy license to conduct business as a non-resident pharmacy in the State of Wyoming for the year ending June 30<sup>th</sup>. The information provided, as well as any attachments, is correct as of the date of this application. I agree to maintain records of all Wyoming prescriptions in a readily retrievable manner, and I will maintain a "toll free" telephone number for the convenience of Wyoming patients.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of Applicant

\_\_\_\_\_  
Title of Applicant

*For Board use only.*

Date received: \_\_\_\_\_ Amount paid: \_\_\_\_\_ Check number: \_\_\_\_\_

State license verified: \_\_\_\_\_ PIC license verified: \_\_\_\_\_

Non-resident pharmacy license number: \_\_\_\_\_ Wyoming Controlled Substance Number: \_\_\_\_\_

Date license mailed: \_\_\_\_\_