APPLICATION FOR REGISTRATION TO MANAGE AND OPERATE
A NEW COMMUNITY PHARMACY
Instructions and Checklist
Application

Instructions:

Use this application to be issued a permit to manage and operate a pharmacy or pharmacy department. The Massachusetts registered pharmacist who is responsible for the management and operation of the pharmacy or pharmacy department must complete this application for registration to manage and operate a pharmacy or pharmacy department and submit it to the Board before the pharmacy or pharmacy department can operate.

The forms and documents listed below must accompany each application.

Checklist:

_____ A completed checklist and application form, fully and properly completed and signed by the pharmacist who is to manage and operate the pharmacy or pharmacy department.

_____ A statement of the scheduled hours during which the pharmacy or pharmacy department is to remain open, including the time of opening and closing during regular business hours for each day of the week.

_____ A check or money order payable to the Commonwealth of Massachusetts for $525.00. NOTE: Cash or foreign currency is not accepted. This fee is non-refundable and non-transferable.

_____ An application for a Massachusetts controlled substance registration. Include a check or money order payable to the Commonwealth of Massachusetts for $225.00. Cash or foreign currency is not accepted.

_____ Blueprint or architectural drawing: see Requirements for Certified Blueprints/Architectural Drawings

Retain a copy of the completed applications and supporting documents for your records.
A copy of the corporation's Articles of Organization, signed and sealed by the Secretary of State if the corporation is incorporated in the Commonwealth.

If the corporation in incorporated is in another state, submit a copy of the corporation's Foreign Corporation Certificate, signed and sealed by the Secretary of State pursuant to M.G.L. c.181, § 4.

A statement of the name and address of each officer and director of the corporation and the position held.

The d/b/a name of the business.

If the corporation is not publicly owned, list the total amount and type of stock issued to each stockholder and the names and addresses of said stockholder(s).

For complete information regarding registration of a new pharmacy or pharmacy department, please refer to 247 CMR 6.01. Board regulations may be found at mass.gov/dph/boards/. If additional information is needed, please contact the Board office at (800) 414-0168. All fees are non-refundable and non-transferable.

Please be advised that no pharmacy or pharmacy department shall begin to operate until the application has been approved by the Board and:

1) The pharmacist Manager of Record has received from the Board a permit number to manage and operate the pharmacy and or pharmacy department
2) The pharmacy or pharmacy department has received a controlled substances registration number.

To obtain a DEA number, please contact the Drug Enforcement Administration (DEA) office for an application. The address is: J.F.K. Federal Building
Drug Enforcement Administration
Room E400
15 New Sudbury Court
Boston, MA 02203-0131
(617) 557-2200

Retain a copy of the completed applications and supporting documents for your records.
I hereby apply for a permit to operate a store for the transaction of retail drug business in accordance with the provisions of Chapter 112, General Laws.

**$525.00 licensure / application fee.** Make check or money order payable to the Commonwealth of Massachusetts. **This fee is non-refundable and non-transferable.**

1. Legal Name of Business. ____________________________________________

2. Full Business Address (Street Address, City, State and Zip). ____________________________________________

3. Area Code and Telephone Number. ____________________________________________

4. All trade or business names (“D.B.A.” names) used by same Corporation or by License. ____________________________________________

5. E-mail address for this community pharmacy: ____________________________________________

6. Type of ownership or operation (i.e., sole proprietorship, partnership, corporation). ____________________________________________

   If corporation, please submit articles of corporation signed and sealed by the Secretary of State if the corporation is incorporated in the Commonwealth; if the corporation in incorporated is in another state, please submit the corporation name, website and phone number.

7. Name and phone number of the contact person for questions regarding this application ____________________________________________

8. Names(s) and Social Security Number(s) of the owner(s) and/or operator(s) of the licensee. **Please indicate type of ownership - Partnerships: the name of each partner and name address of partnership; Corporations: the name and title of each corporate officer and director, the corporate names, name and address of parent company, if any, and the State of incorporation; Sole Proprietorship: the name of the sole proprietor and the address of the business entity**

**Retain a copy of the completed applications and supporting documents for your records.**
9. Name of registered pharmacist charged with the management of the pharmacy.

10. Registration number of above manager.

11. Name(s) and registration number(s) of staff pharmacist(s) employed at pharmacy.

12. (a) Have any of the applicant(s) and/or managers-in-charge had: 1) any convictions related to the distribution of drugs (including samples); 2) any felony convictions; 3) any suspension(s) or revocation(s) or other sanction(s) by federal, state or local governmental agency of any license or registration currently or previously held by the applicant or license for the manufacture, distribution, or dispensing of any drugs, including controlled substances? Yes _________ No _________
If yes, provide a full explanation. (Attach additional sheets if necessary)

(b) Have any applications for licensure been denied by any federal or state agency including any state board of pharmacy? List and explain. (Attach additional sheets if necessary)

13. The applicant/licensee must notify the Board in writing of any changes in ownership or management within thirty (30) days of such change(s).

14. Social Security Number of the Pharmacy Manager (Mandatory).

Pursuant to M.G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax laws of the Commonwealth.

15. List any licenses/certifications held by the Pharmacy Manager in the United States or any country or foreign jurisdiction and the state/jurisdiction from which the license/certification was originally issued. Please include a certificate of standing from each state or jurisdiction in which you are licensed/certified in a signed sealed envelope. The verification must indicate the status of your license and any relevant disciplinary information. (Attach additional sheets if necessary)

16. Has any disciplinary action been taken against you by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes _________ No _________
If yes, please state the details (Attach additional sheets if necessary)

17. Are you the subject of pending disciplinary actions by a licensing/certification board located in the United States or any country or foreign jurisdiction? Yes _________ No _________
If yes, please state the details (Attach additional sheets if necessary)

Retain a copy of the completed applications and supporting documents for your records.
18. Have you ever voluntarily surrendered or resigned a professional license to a licensing/certification board in the United States or in any country or foreign jurisdiction? Yes ______ No ________
   If yes, please state the details (Attach additional sheets if necessary)

19. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction? Yes ______ No ________
   If yes, please state the details (Attach additional sheets if necessary)

20. Pursuant to Board Regulations at 247CMR δ 6.01(3), **The Board shall not register nor permit ownership of a pharmacy or pharmacy department by a practitioner with prescriptive privileges.** By signing this application the applicant certifies that none of the owners, directors or officers have prescriptive privileges.

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**AFFIDAVIT (MUST BE COMPLETED AND NOTARIZED)**

Pursuant to M.G.L. c. 62C, s. 49A, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

The applicant certifies that each person employed in any prescription drug distribution activity has the education, training, and experience, or any combination thereof, sufficient for that person to perform the assigned functions in such a manner as to provide assurance that the drug product quality, safety, and security will at all times be maintained as required by law.

I hereby state that I am the person authorized to sign this application for all licensure; that all statements are true and correct in all respects and are made under the penalties of perjury.

________________________________________
Signature of pharmacist who is to manage the pharmacy or pharmacy department

________________________________________
Date

---

**Social Security Number of the Manager of Record**

Sworn and subscribed before me this ______ day of ________

Notary Public signature

My commission expires

---

**TO BE COMPLETED BY BOARD**

Check $_________ Date_________ Number_________

**Retain a copy of the completed applications and supporting documents for your records.**
# Requirements for Certified Blueprints/Architectural Drawings

<table>
<thead>
<tr>
<th>Retail Drugs Store</th>
<th><strong>A certified blueprint/architectural floor plan</strong> with the pharmacy outlined in RED, drawn to scale with the following items clearly labeled:</th>
</tr>
</thead>
</table>
| Simple and Moderate compounding only | 1. square footage  
2. prescription area  
3. patient consultation area  
4. drop off and pickup windows  
5. pick-up bins  
6. refrigerator  
7. safe  
8. sink  
9. non-sterile compounding counter and  
10. hazardous materials storage |

<table>
<thead>
<tr>
<th>Complex Non-Sterile</th>
<th><strong>A certified blueprint/architectural floor plan</strong> with the pharmacy outlined in RED, drawn to scale with the following items clearly labeled:</th>
</tr>
</thead>
</table>
|                      | 1. Square footage  
2. prescription area  
3. patient consultation area  
4. drop off and pickup windows  
5. pick-up bins  
6. refrigerator  
7. safe  
8. sink  
9. non-sterile compounding counter and  
10. hazardous materials storage  
11. the designated dedicated compounding room, including placement of containment hood(s);  
12. detailed HVAC design plan and written description |

<table>
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<tr>
<th>Sterile Compounding</th>
<th><strong>A certified blueprint/architectural floor plan</strong> with the pharmacy outlined in RED, drawn to scale with the following items clearly labeled.</th>
</tr>
</thead>
</table>
|                      | 1. Square footage  
2. prescription area  
3. patient consultation area  
4. drop off and pickup windows  
5. pick-up bins  
6. refrigerator  
7. safe  
8. sink  
9. non-sterile compounding counter  
10. hazardous materials storage  
11. proposed pharmacy layout outlined in red, include square footage of each room;  
12. a legend explaining all abbreviations;  
13. location and ISO classification of each primary and secondary engineering control;  
14. air flow;  
15. room pressurization;  
16. HVAC details;  
17. location of any pass-throughs and  
18. other pertinent details |

**A Certified Blueprint/Architectural floor plan must be stamped with a architect’s seal along with the architects signature.**
ATTESTATION OF INTENT TO CONDUCT NONSTERILE COMPOUNDING

All pharmacies licensed by the Massachusetts Board of Registration in Pharmacy (Board) that perform nonsterile compounding are required to prepare and dispense medications in compliance with state and federal laws and regulations; particularly, United States Pharmacopeia (USP) Standard <795> for nonsterile products. All new Community Pharmacy Applicants are required to complete and submit this ATTESTATION OF INTENT TO CONDUCT NONSTERILE COMPOUNDING as part of a complete application.

USP <795> Pharmaceutical Compounding – Nonsterile Preparations defines compounding as “the preparation, mixing, assembling, altering, packaging, and labeling of a drug, drug-delivery device, or device, in accordance with a licensed practitioner’s prescription, medication order or initiative based on the practitioner/patient/pharmacist/compounder relationship in the course of professional practice. Compounding includes the following:

• Preparation of drug dosage forms for both human and animal patients
• Preparation of drugs or devices in anticipation of prescription drug orders based on routine, regularly observed prescribing patterns
• Reconstitution or manipulation of commercial products that may require the addition of one or more ingredients
• Preparation of drugs or devices for the purposes of, or as an incident to, research (clinical or academic), teaching, or chemical analysis
• Preparation of drugs and devices for prescriber’s office use where permitted by federal and state law”

Please direct any questions regarding this Attestation to admin@massmail.state.ma.

Name of Massachusetts Pharmacy ________________________________________________________________
Street Address ___________________________________________________________________________________________
City/Town ___________________________   Zip Code _________________
Tel. No. ___________________________  Fax No. ___________________________
Facility E-mail ________________________________________________________________________
Date Application for New Community Retail Pharmacy send to the Board _____________
Name of Manager of Record _______________________________ Lic. No. PH_____________
E-mail ________________________________________________________________________
Name of Owner(s) ________________________________________  Lic. No. PH____________
________________________________________  Lic. No. PH____________
________________________________________  Lic. No. PH____________
________________________________________  Lic. No. PH____________

1. The pharmacy will engage in the compounding of nonsterile preparations.

Yes ____   No ____
A. If you have answered NO, please complete page 6.
B. If you have answered YES, you must complete the following pages, IN ENTIRETY.

2. What USP categories of Compounded Nonsterile Preparations will the Pharmacy prepare? Check all that apply. For definitions of the categories, please refer to USP <795> Pharmaceutical Compounding—Nonsterile Preparations.

_____ Simple
_____ Moderate
_____ Complex
3. List all current accreditations the pharmacy has obtained. Attach a copy of the accreditation.

________________________________________
________________________________________
________________________________________
________________________________________
____ NOT accredited

4. List all other registrations below related to the Massachusetts Pharmacy (e.g. manufacturer, wholesale distributor, re-packer, re-labeler). Do not include the MA Drug Store Permit No. Attach additional pages as necessary.

DEA Registration No. _______________________
FDA Registration No. ________________________ (manufacturer/distributor only)
DPH Drug Control Program Manufacturer/Distributor
   Registration No. __________________________ (manufacturer/distributor only)
DPH Drug Control Program MA Controlled Substance Registration (MCSR)
   Registration No. __________________________
Other: ____________________________________

5. Hours of operation: Weekdays: __________ Weekends: __________

6. Total number of Pharmacy Staff at opening: Pharmacists: _______ Technicians: _______ Interns: _______

7. Number of staff who will prepare nonsterile compounded products: Pharmacists: _______ Technicians: _____ Interns: _____

8. Will you provide routine compounding competency training and assessment for all compounding personnel?
   Yes ____ No ____
   If yes, how often? ____________________________________________________________

9. Circle all states and jurisdictions outside of Massachusetts that the Pharmacy dispenses Compounded Nonsterile Preparations to:

Alabama  Illinois  Nebraska  South Carolina
Alaska    Indiana  Nevada   South Dakota
Arizona   Iowa     New Hampshire  Tennessee
Arkansas  Kansas  New Jersey  Texas
California Kentuckv New Mexico  Utah
Colorado  Louisiana New York   Vermont
Connecticut Maine  North Carolina  Virginia
Delaware  Maryland North Dakota  Washington
D.C.      Michigan Ohio   West Virginia
Florida   Minnesota Oklahoma  Wisconsin
Georgia   Mississippi Oregon   Wyoming
Hawaii    Missouri Pennsylvania Other: ______________
Idaho     Montana Rhode Island Other: ______________

Name of Pharmacy: ___________________________________________________________ 2
10. Indicate the approximate number of Compounded Nonsterile Preparations that the Pharmacy is anticipated to dispense within 6 months of opening. For reference, a batch of a preparation that is dispensed to 5 different patients is counted as 5 prescriptions. In computing the number of prescriptions compounded, consider the amount of compounding conducted in the 365 days immediately preceding the calculation (not the calendar year). This calculation should ONLY include NONSTERILE COMPOUNDED prescriptions dispensed.

-  under 20 nonsterile compounded prescriptions per day
-  20 to 50 nonsterile compounded prescriptions per day
-  50 to 100 nonsterile compounded prescriptions per day
-  100 nonsterile compounded prescriptions per day
-  100 to 250 nonsterile compounded prescriptions per day
-  250 to 500 nonsterile compounded prescriptions per day
-  over 500 nonsterile compounded prescriptions per day

11. What types of Compounded Nonsterile Preparations will the Pharmacy prepare? Check all that apply.

- Topicals (e.g. creams, ointments, lotions, gels, etc)
- Oral liquids (e.g. solutions, suspensions, etc)
- Oral dosages (e.g. capsules, tablets, etc)
- Suppositories
- Troches
- Transdermal
- Veterinary
- Other: __________________________________________________________

12. Does the pharmacy have a designated nonsterile compounding area(s) in accordance with USP <795> Pharmaceutical Compounding—Nonsterile Preparations?

- Yes ___ No ___ N/A ___

13. List all special equipment (e.g. powder hood) used in compounding:

____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

14. Have all automated, mechanical, electronic, and other types of equipment used in compounding or testing of compounded preparations routinely inspected and/or calibrated as necessary, and checked to ensure proper performance?

- Yes ___ No ___ Not sure ___ Scheduled for date _____________

A. Attach a copy of all equipment certifications provided by third-party testing vendors.

15. Are all balances within the pharmacy sealed in accordance with 247 CMR 6.01(5)(a)(4)?

- Yes ___ No ___

16. Will the pharmacy utilize nonsterile active pharmaceutical ingredients (APIs) for compounded preparations?

- Yes ___ No ___

17. Are all nonsterile active pharmaceutical ingredients (APIs), substances and excipients official USP or NF grade?

- Yes ___ No ___

Name of Pharmacy: ____________________________________________
A. If not, are all nonsterile ingredients, substances, and excipients from an FDA approved manufacturer or distributor?
   Yes ____  No ____

B. If all nonsterile ingredients, substances, and excipients are not from an FDA approved manufacturer or distributor, have
   the active pharmaceutical ingredients (APIs) been certified through independent analysis?
   Yes ____  No ____
   a. If yes, state the name of the any active ingredient(s) and provide documentation of certification:
      ________________________________  
      ________________________________  

18. Will the pharmacy use purified water for compounding nonsterile drug preparations when formulations indicate the
   inclusion of water?
   Yes ____  No ____

19. Will the pharmacy utilize hazardous (NIOSH) drugs for nonsterile compounded preparations? For a list of NIOSH
   Yes ____  No ____

A. If yes, describe the storage of hazardous (NIOSH) drugs used in nonsterile compounding:
   ________________________________  
   ________________________________  
   ________________________________  

B. If yes, does the pharmacy have a policy requiring all personnel who compound hazardous drugs to be fully trained in the
   storage, handling, and disposal of hazardous (NIOSH) drugs?
   Yes ____  No ____

20. Will the pharmacy assign Beyond-Use Dating (BUD) in accordance with USP <795> Pharmaceutical Compounding
   Nonsterile Preparations for all nonsterile compounded preparations?
   Yes ____  No ____
   A. If no, describe the pharmacy’s methodology for determining the BUD for Compounded Nonsterile Preparations:
      ________________________________  
      ________________________________  

21. Will the pharmacy maintain and follow a Master Formulation Record in accordance with USP <795> Pharmaceutical
   Compounding Nonsterile Preparations that is followed each time a nonsterile preparation is compounded?
   Yes ____  No ____

22. The pharmacy will maintain and complete a Compounding Record in accordance with USP <795> Pharmaceutical
   Compounding Nonsterile Preparations each time a nonsterile preparation is compounded.
   Yes ____  No ____

23. The Pharmacy will only dispense compounded nonsterile preparations after receipt of a valid prescription.
   Yes ____  No ____

Name of Pharmacy: ___________________________________________________________ 4
A. The Pharmacy will maintain and have available standard operating policies and procedures (SOPs) for preparing compounded nonsterile preparations in conformance with USP standards.

   Yes   ____    No     ____   Not Sure     ____

24. Will the pharmacy have a Quality Assurance Program in conformance with USP standards?

   Yes   ____    No     ____

25. Will the Pharmacy complete a USP <795> Gap Analysis within the next 12 months?

   Yes   ____    No     ____

26. Attach a list of all products you would expect to compound in the next 6 months.

Name of Pharmacy: ___________________________________________________________ 5
I, _________________________________________________________________ (Manager of Record) ATTEST,
under the pains and penalties of perjury, to the truthfulness of the information provided herein,
that ______________________________________________________________ (Name of Pharmacy)

WILL / WILL NOT (circle one) engage in the compounding of nonsterile preparations and that all
nonsterile compounding pharmacy practices are in COMPLIANCE WITH ALL Massachusetts Board of Registration
Pharmacy regulations (247 CMR) and USP <795> Pharmaceutical Compounding – Nonsterile Preparations in the
compounding of nonsterile preparations.

MOR Signature ___________________________________________ Date ________________

Please direct any questions regarding this Attestation to .admin@massmail.state.ma.

Please mail the original signed Attestation AND requested information to the Massachusetts Board of Registration
Pharmacy at the address below:

Board of Registration in Pharmacy
ATTN: Nonsterile Compounding Attestation
239 Causeway Street, floor
Boston, MA 02114

Name of Pharmacy: ___________________________________________________________
ATTESTATION OF INTENT TO CONDUCT STERILE COMPOUNDING

As part of the application for a community pharmacy in Massachusetts which intends to conduct sterile compounding, the owners and manager of record must complete and sign this form under the Pains and Penalties of Perjury.

DBA Name of Pharmacy
Street Address
City/Town Zip Code
Tel. No. Fax No.
E-mail

A. STERILE COMPOUNDING ACTIVITY:

1. Please provide a reasonable estimate of the number of prescriptions you anticipate your pharmacy will dispense monthly during its first year of licensure. For any of the USP General Chapter 797 risk-level category (low, medium, high risk level) that you have no plans to compound, please write N/A.

   Low-Risk Level Compounding: single volume transfers of not more than 3 sterile dosage forms and not more than 2 entries into a sterile container (e.g., hydrating solutions, irrigations, antibiotics and oncology medications). Anticipated # per month 

   Medium-Risk Level Compounding: the compounding process includes complex aseptic manipulations other than single volume transfer (e.g., TPN, cardioplegia solutions, multiple sterile ingredient admixtures). Anticipated # per month 

   High-Risk Level Compounding: non-sterile ingredients, including manufactured products not intended for sterile routes of administration, are incorporated or a non-sterile device is employed before terminal sterilization. Anticipated # per month
2. Does your Pharmacy intend to dispense Compounded Sterile Preparations (CSPs) to any states and/or jurisdictions outside of Massachusetts?  □ Yes  □ No

If Yes, list all states and/or jurisdictions outside of Massachusetts, and status of non-resident licenses:

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<tr>
<th>State/Jurisdiction</th>
<th>Licensure Status</th>
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3. List all wholesale distributors and any other sources that the Pharmacy expects to receive products from, including chemicals and medications required to produce CSPs (use additional pages if necessary):

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

4. List all manufacturers that provide the Pharmacy with unsterile Active Pharmaceutical Ingredients (API) (use additional pages if necessary):

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

5. Where in your facility will hazardous materials be stored?

_____________________________________________________________________

Pharmacy Name: _______________________

2
B. STAFFING/TRAINING/COMPETENCY EVALUATIONS:

1. List all Pharmacy personnel who will engage in preparing CSPs. Attach an organizational chart (management), and additional pages if necessary.

<table>
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<tr>
<th>Name</th>
<th>Title</th>
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2. Do all staff involved in compounding sterile preparations have documented training consistent with USP General Chapter 797?  ☐ Yes  ☐ No

3. Will all staff involved in compounding sterile preparations undergo a regularly scheduled (at least annually) competency validation?  ☐ Yes  ☐ No

   If Yes, specify frequency: _________

C. QUALITY ASSURANCE:

1. Does the pharmacy have vendor ISO certification for:

   Hoods?  ☐ Yes  ☐ No  #Hoods__________  #Hoods certified__________

   Compounding Aseptic Isolators (CAIs) / Glove box?
     ☐ Yes  ☐ No  #CAIs__________  #CAIs certified__________

   Ante and buffer areas and any other applicable ISO environments?
     ☐ Yes  ☐ No

2. Regarding sterilization procedures, is the pharmacy in compliance with currently acceptable and achievable sterilization parameters, e.g., temperature, time, humidity, gas concentration, absorbed radiation and biological indicators (BI’s) as needed for validation?  ☐ Yes  ☐ No

Pharmacy Name: _______________________

3
3. When was the most recent USP General Chapter 797 Gap Analysis completed?  
______________

4. Does the Pharmacy have a data driven Quality Assurance/Performance Improvement Program?  
   Yes  No

5. If the facility does not use USP General Chapter 797 Beyond-Use Dating, describe your facility’s methodology for determining Beyond-Use Dating for CSPs.

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

D. COMPLIANCE/SANCTIONS:

1. Will the pharmacy prepare and dispense Compounded Sterile Preparations only after receipt of a valid prescription for a single patient?  
   Yes  No

2. Does the pharmacy maintain a written policy and procedure manual for preparing Compounded Sterile Preparations in conformance with USP General Chapter 797?  
   Yes  No

3. Is all pharmacy equipment used to prepare Compounded Sterile Preparations stored, used, and maintained in accordance with manufacturer specifications?  
   Yes  No

Pharmacy Name: _______________________

4
ATTESTATION OF INTENT TO CONDUCT STERILE COMPOUNDING

Attestation regarding compliance with laws and regulations:

The pharmacy licensee/registrant attests under the pains and penalties of perjury that it is in compliance with all laws and regulations pertinent to sterile compounding, including USP General Chapter 797 - Sterile Preparations. This registrant/licensee only prepares and dispenses medication pursuant to a valid prescription as defined in M.G.L. c. 94C for a single patient, regardless of whether the medication is prepared for a Massachusetts or out-of-state patient.

Print Name of Manager of Record (Licensee/Registrant): ________________________________

Title: ________________________________________________________________________

License Number: __________________________________________________________________

Signature of Manager of Record: __________________________________________________

Date: __________________________

Please direct any questions regarding this form to .admin@massmail.state.ma.

Mail the completed and signed form and other requested information to the Massachusetts Board of Registration in Pharmacy:

Board of Registration in Pharmacy
ATTN: Compounding Report
239 Causeway Street, floor
Boston, MA 02114

A signed copy may be faxed to 617. 973. 0980 or scanned and emailed to .admin@massmail.state.ma, in advance of submission by mail of the signed, original document.

Pharmacy Name: _______________________

5
I hereby apply for a Massachusetts Controlled Substances Registration in accordance with M.G.L. c. 94C, § 7:

Name of Corporation/Applicant _____________________________________________________

Street Address ________________________________________________________________

City/Town ___________________________ State _________ Zip Code __________

Tel. No. _______________________________ Fax No. _________________________________

E-mail ________________________________________________________________

FEIN Number: __________________________

Registration Classification:

☐ Drug Store Pharmacy

☐ Complex Non-Sterile Compounding Pharmacy  ☐ Sterile Compounding Pharmacy

Please check applicable controlled substance(s):

☐ Schedule II ☐ Schedule III ☐ Schedule IV ☐ Schedule V ☐ Schedule VI**

** Schedule VI: This substance is a prescription drug that has not already been included in Schedules I-V.

Signature of Applicant: __________________________________________________________

(Owner of facility must sign application)

Printed Name of Applicant whose signature appears above: _______________________________

TO BE COMPLETED BY BOARD

CHECK $ ______________ DATE __________

CHECK NO. ____________ RECEIPT NO. ____________ APP NO. ____________

LICENSE NO. ____________ / ____________

__________________________ / __________________

Revised: 4/26/19  Page 1 of 1

Name of Pharmacy: ________________________________
Name of Pharmacy: _________________________________________________________

Street Address: ____________________________________________________________

City/Town: ___________________________ State: ___________ Zip Code: ___________

Tel. No: ___________________________ Fax No: _________________________________

Pharmacy E-mail: ___________________________________________________________

<table>
<thead>
<tr>
<th>Days</th>
<th>Open</th>
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<td>Monday</td>
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<td><strong>Total per week</strong></td>
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</table>

Please describe how a patient may contact a pharmacist for questions or refill their prescription when the pharmacy is closed.

License No: _________________________________________________________________

Signature of Manager of Record or Duly Authorized Representative

Date: ________________________________

Print Full Name: ________________________________

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