STATE OF NEBRASKA
DEPARTMENT OF HEALTH & HUMAN SERVICES
Division of Public Health
Licensure Unit
P. O. Box 94986
Lincoln, NE 68509-4986

APPLICATION TO AMEND A LICENSE TO OPERATE A PHARMACY

- ✓**FOR ALL 3 AMENDMENT SITUATIONS**: Submit (1) an ORIGINAL **amendment form** *AND* (2) the ORIGINAL **pharmacy license**.
- ✓**FOR PIC AMENDMENTS**: In addition to (1) the ORIGINAL **amendment form** and (2) the ORIGINAL **pharmacy license**, submit *AND* (3) a COPY of the **controlled substance inventory** taken AT THE TIME OF PIC CHANGE. **There is NO GRACE PERIOD for the pharmacy to be without a PIC.** The required materials for change of PIC must be submitted to the Department within 30 days after the actual PIC change.
- ✓Keep a copy of the information you send to the Department.
- ✓There is not a fee to amend a license. Location and change of ownership cannot be amended on an existing license. Both require the issuance of a new license.

SECTION A – PHARMACY FACILITY INFORMATION:

PHARMACY INSPECTOR'S NAME: ______________________________

PHARMACY NAME: ____ LICENSE NUMBER: ____________

PHARMACY ADDRESS: ____
(Street/P.O. Box/Route)

____
(City) (State) (Zip) (Phone Number)

NAME OF OWNER(S), PARTNERS OR CORPORATION: ____

____

____

IF CORPORATION, NAME OF CORPORATE OFFICERS:____

____

____

OWNER ADDRESS:____
(Street/P.O. Box/Route)

____
(City) (State) (Zip)

SECTION B - REASON FOR AMENDING PHARMACY LICENSE:

_______ 1. **CHANGE OF PHARMACIST-IN-CHARGE**
(Must be filed within 30 days of change of PIC)

Effective Date of change: ____________________

Previous pharmacist in charge____ Lic #_______________________________

New pharmacist in charge____ Lic #________________________

NOTE: A copy of a controlled substances inventory taken pursuant to a change in the pharmacist-in-charge must be forwarded to the Department within 30 days after completion.

_______ 2. **CONTINUATION OF PHARMACY LICENSE BY HEIRS OR ESTATE OF DECEASED LICENSEE**
(Must be filed within 30 days of death)

Effective Date of change: ____________________

Name of deceased licensee:____

Date of death: ____

Name of heirs/estate: ____

Name of pharmacist in charge:____ Lic.#________________________________

________ 3. **NAME CHANGE**:
(Licensee must notify the Department within 5 working days when there is a change in the name of the pharmacy)

Effective Date of change: ____________________

Current Name:____

New Name:____

SECTION C - AFFIDAVIT

I do solemnly swear and affirm that I am the person authorized to sign this application to amend a pharmacy license and that all the statements made are true and complete in all respects.

____
(Legal Signature of Authorized Person)

____
(Printed Name and Title)

____
(Date)