

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 REMOTE DISPENSING 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 – LICENSE INFORMATION:**

PHARMACY INSPECTOR'S NAME: \_\_\_\_\_

REMOTE DISPENSING 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. **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)