



# Louisiana Board of Pharmacy

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## Application for Renewal of an Emergency Drug Kit (EDK) Permit for Year 2016-2017

Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Pharmacy City, State, ZIP: \_\_\_\_\_

Pharmacy Permit No.: \_\_\_\_\_

\$25	If postmarked, hand-delivered, or placed with a mail carrier <b>on or before June 30, 2016</b>
\$37.50	If postmarked, hand-delivered, or placed with a mail carrier <b>on or after July 1, 2016</b>
Checks only. Payable to <b>LA Board of Pharmacy</b>	

### The permit for the EDK located at this facility shall expire on June 30, 2016.

**Note:** Permits are not transferable. If ownership of the provider pharmacy or facility has changed, a new permit is required.

#### TO CANCEL PERMIT:

1. Write "CANCEL" across form
2. Obtain PIC signature below
3. Return form to Board by June 30, 2016

#### TO RENEW PERMIT:

1. Line through the incorrect data and legibly print or type the correct data; attach additional sheet if necessary
2. Enter facility ownership information
3. Obtain original signature of provider pharmacy's Pharmacist-in-Charge **AND** Administrator of Facility
4. Submit completed application, attachments and application fee to the above address

<u>Long-Term Care Facility:</u>	<u>Long-Term Care Facility Ownership:</u>
EDK Permit No. EDK. _____ DHH Lic. No. _____	Name: _____
Facility Name: _____	Address: _____
Facility Address: _____	Address: _____
City, State, ZIP: _____	City, State Zip: _____
Telephone (_____) _____-- _____	Telephone (_____) _____-- _____

In accordance with the Board's laws and rules, application is hereby made to renew the permit for an Emergency Drug Kit at the Long-Term Care Facility named above. The submission of any false information on any portion of this application is a violation of La. R.S. 37:1241.A(2) and may result in denial of this application, or if issued, the suspension or revocation of the permit.

\_\_\_\_\_  
Print Name of PIC

\_\_\_\_\_  
RPh Lic. No.

\_\_\_\_\_  
Print Name of Administrator

\_\_\_\_\_  
Original Signature of Provider Pharmacy PIC  
Must match current PIC of Record

\_\_\_\_\_  
Original Signature of Facility Administrator