



The Commonwealth of Massachusetts
 Executive Office of Health and Human Services
 Department of Public Health
 Division of Health Professions Licensure

Board of Registration in Pharmacy
 239 Causeway Street, Suite 200, 2nd Floor
 Boston, MA 02114

<http://www.mass.gov/dph/boards/ph>

PH (617) 973-0960 FAX (617) 973-0980 TTY (617) 973-0895

**APPLICATION FOR REGISTRATION TO OPERATE AND MANAGE
 A NUCLEAR PHARMACY**

\$525.00 Licensure / Application fee. Please include a certified check, money order, or personal check made payable to the Commonwealth of Massachusetts.

1. Nuclear pharmacies must be licensed (Radioactive Materials License) by the Department of Public Health, Radiation Control Program (DPH / RCP) prior to registration by the Board of Registration in Pharmacy.

Documentation of DPH / RCP licensure is attached. Yes _____

DPH / RCP license number _____

2. Name of nuclear pharmacy _____

3. Location of nuclear pharmacy for which registration is requested.

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No.	Street	Telephone
City or Town	State	Zip Code

4. Hours of operation of nuclear pharmacy.

Day	From	To
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

5. E-mail address for this Nuclear Pharmacy: _____

6. If the nuclear pharmacy is owned by an individual, state:

Name of owner _____

Address _____

Social Security Number _____

7. If the nuclear pharmacy is owned by a partnership, state:

Partnership name _____

Address _____

FID # _____

8. If the nuclear pharmacy is owned by a corporation, state:

a. Corporation name _____

Address _____

FID # _____

b. State in which company is incorporated _____

c. Names of Corporate Officers

Name	Position

9. Pharmacist charged with the management of the nuclear pharmacy must be a Massachusetts registered pharmacist, and have been qualified by the Board as a nuclear pharmacist.

a. Name of pharmacist manager _____

b. Mass. Pharmacist Registration Number _____

c. Date of qualification by the Board as a nuclear pharmacist _____

Month Day Year

d. Social Security Number _____

10. Name of other Massachusetts registered pharmacists in employment. If registered as nuclear pharmacists, state regulation numbers.

Name	Pharmacist #	Nuclear Pharmacist #

11. (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, radiopharmaceuticals and radioactive materials? 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 and or foreign jurisdiction? Yes _____ No _____

If yes, provide a full explanation. (Attach additional sheets if necessary)

*If you answered “Yes” to Question “11a or 11b”, you must attach a certified copy of each action and or court setting forth circumstances of such action(s).

Pursuant to M.G.L. Chapter 62C section 49A, the company certifies that it has complied with all laws of the Commonwealth relating to state taxes.

We hereby certify that we have read and understand all applicable state and federal statutes and regulations regarding the operation of nuclear pharmacies and the handling of radiopharmaceuticals and radioactive materials, including M.G.L. Chapter 94C and Chapter 112, and 247 CMR 11.00 through and including 11.05.

WARNING:

In accordance with Chapter 94 M.G.L. Sec 13, the Board of Registration in Pharmacy in the case of a retail drug business or wholesale druggist, may suspend or revoke a registration to manufacture, distribute, dispense or possess a controlled substance after a hearing pursuant to the provisions of Chapter 34A and upon finding that the registrant has furnished false or fraudulent information in any application filed under the provisions of Chapter 94C.

RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS.

ALL FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE

Signature of Owner, Partner, or Corporate Officer _____
Date _____

Signature of Proposed Pharmacy Manager _____
Date _____

Sworn and subscribed before me this _____ day of _____

My commission expires _____

Name of Notary Public

NOTARY SEAL

To be completed by the Board: Check \$ _____ Date _____ Number _____