Bureau of Professional Licensing
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NOTIFICATION OF PHARMACY OPERATING AN AUTOMATED DEVICE AT AN AFFILIATED LOCATION (NON-CONTROLLED SUBSTANCES)

Authority: 1978 PA 368

Note: This application is only for a pharmacy that is owned and operated by a hospital, as defined in MCL 333.20106 operating an automated device that will NOT contain controlled substances at a location affiliated with the hospital but that is not located at the same physical address as the pharmacy. (Note: Do not use this form if the automated device will contain controlled substances.)

Provide the following information which appears on your primary Pharmacy license.

Business Name:		
Primary Street Address:		Suite #:
City:	State:	Zip Code:
Telephone Number:	Email Address:	
10-Digit Permanent ID/License Number of Michigan Pharmacy:		Expiration Date:

AUTOMATED DEVICE MUST BE UNDER THE CONTROL AND SUPERVISION OF THE HOSPITAL PHARMACIST-IN-CHARGE

Name of Pharmacist-in-Charge (PIC) of Hospital Pharmacy:	Michigan Pharmacist License Number: **5302 -**

Have any sanctions been imposed against the pharmacy by a similar licensure, registration, certification, or disciplinary board of another state or country that has not been previously reported to the Department?

☐ Yes ☐ No

Have any sanctions been imposed against the pharmacist-in-charge by a similar licensure, registration, certification, or disciplinary board of another state or country that has not been previously reported to the Department?

☐ Yes ☐ No

(Revised 4/2017)

PROVIDE THE FOLLOWING INFORMATION FOR THE ADDITIONAL LOCATION:		
Business Name:		Identification Number of Automated Device:
Street Address:	Suite #:	
City:	State:	Zip Code:
Telephone Number:	Email Address:	

CERTIFICATION AND SIGNATURE

I consent to the release of information regarding a disciplinary investigation conducted by a similar licensure, registration, or specialty licensure or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country. I certify that the statements in this application are true and complete. I understand that any omitted statement, misrepresentation, or fraud may be cause for denial of my application, disciplinary action, or may be punishable by law. I understand the applicable federal and state laws and administrative rules regarding the operation of an automated device pursuant to **Article 15 of the Public Health Code, 1978 PA 368, MCL 333.16101 to 333.18838**. **I further understand that the device cannot be stocked with controlled substances**.

_____ _____

Signature Date