CABINET FOR HEALTH
AND FAMILY SERVICES
Office of the
Inspector General

OIG-20:365B, November 2022

Application for Participation in the Abortion-Inducing Drug Certification Program

- If you have questions regarding this registration form, please call (502) 564–7963.
- Please answer all questions completely and accurately. Supporting documentation must be attached. An incomplete or illegible application will be returned without being processed.
- A non-refundable fee in the amount of $155 for initial certification or annual renewal must accompany this application. Approval will not be issued without receipt of this fee.
- A renewal application and fee shall be submitted at least 30 days prior to the date of expiration of the current certification.
- Please return the application, required documents, and a non-refundable registration fee payable to the Kentucky State Treasurer to:

Cabinet for Health and Family Services
Office of Inspector General
Division of Health Care
275 E. Main St., 5 E-A
Frankfort, KY 40621

The undersigned hereby registers to transport, supply, sell, or dispense abortion-inducing drugs subject to the requirements of KRS 216B.200 – 216B.210 and 902 KAR 20:365.

A. Type of Application

☐ Initial Certification ☐ Annual Recertification

☐ Change of Name ☐ Change of Location

B. Identification

1. Agency Name _____

2. Agency Street Address _____
   (P.O. Box without a street address is not acceptable.)

3. Agency City/State/Zip _____

4. Telephone Number _____ Email Address _____

5. After Hours Number _____ Fax Number _____

6. Name of county in which the agency is located _____

7. Name of county/counties in which the agency provides services _____

C. Applicant Business Type (Check one in each column.)

- ☐ Manufacturer
- ☐ Distributor
- ☐ Pharmacy
- ☐ Abortion Facility
- ☐ Limited Liability Company
- ☐ Sole Proprietorship
- ☐ Partnership
- ☐ Corporation
- ☐ Other Ownership _____

1. List the name of the corporation, association, person, or partners legally responsible for the operation of this agency.

   _____

2. Federal ID # _____ State Tax ID # _____

3. If a corporation, list the date and place of incorporation _____

   Attach a Certificate of Authority to do business in Kentucky if incorporated in another state.

4. President _____

6. Agent(s) _____
   (Individual(s) authorized to transact business with the Cabinet for Health and Family Services and upon whom all notices and orders shall be served. Include address if different from the above address. Please attach another sheet of paper if necessary.)

   Address _____ City, State, Zip _____

D. Management Agent (if different from owner)

Name _____

Street Address _____ City, State, Zip _____

E. Verification

I understand that I am required to report any change in the information provided within this application that affects my registration status to the Office of Inspector General and complete a new application at that time. I agree that this agency and all aspects of its operation shall be open at all times during regular business hours to allow state agency personnel entrance upon its premises for the purpose of inspection. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application shall result in the denial or revocation of registration.

_____	_____
Signature of Authorized Representative	Title
_____	_____
Name (please print or type)	Date

F. Documentation

Documentation to be submitted with the initial registration application. *(Re-submission of these documents is not required as part of an updated application unless they are different from the original documents submitted at the time of initial registration.)*

The following documents must be received before your application is considered complete:

- If applicable, evidence of Kentucky licensure as a distributor, or a Kentucky permit as a pharmacy or manufacturer as required by KRS 216B.204(2)(a).
- If engaging in online sales or orders, evidence of a current pharmacy or pharma domain as required by KRS 216B.204(2)(d).
- For pharmacies, as required by KRS 216B.204(3):
    - Evidence of certification by the U.S. Food and Drug Administration (FDA) to dispense abortion-inducing drugs within 180 days after the FDA implements its certification program; and
    - Evidence of certification by the drug manufacturer for the distribution of abortion-inducing drugs within 180 days after the manufacturer implements its certification program.
- For abortion facilities, a copy of the current license.

Attestation Statement Regarding Certification

(Read this statement carefully before signing.)

Based on my personal knowledge and belief, I attest that the responses on this statement regarding compliance with KRS 216B.200 – 216B.210 and 902 KAR 20:365 related to certification to transport, supply, sell, or dispense abortion-inducing drugs are true and correct.

(Type or print name of entity) _____, a (type or print entity type) _____, declares that:

- It will only distribute to or fulfill prescriptions requested by registered, qualified physicians as required by KRS 216B.204(2)(b).
- It will abide by all applicable National Association of Boards of Pharmacy (NABP) standards (if applicable) as required by KRS 216B.204(2)(c).
- It will abide by NABP online domain standards (if applicable) as required by KRS 216B.204(2)(d).
- It will follow all other applicable state or federal laws related to the dispensation, distribution, or delivery of legend drugs, including abortion-inducing drugs, as required by KRS 216B.204(2)(e).
- It will follow all acceptable process and procedures as set out in KRS 216B.204(2)(f).
- If a pharmacy, it will only fulfill prescriptions that are accompanied by the required patient consent form as required by KRS 216B.204(3).

I understand that the Kentucky Cabinet for Health and Family Services may conduct an onsite visit at any time to examine records to validate that the statements made above are true and correct.

Name _____
(Typed or Printed)

Signature _____
(Authorized Representative)

Title _____ Date _____