

# Pharmacy Renewal Application



TEXAS STATE BOARD OF PHARMACY  
333 Guadalupe St., Suite 3-600  
Austin, TX 78701  
(512) 305-8022

License Number: 17438  
COMAL CO. HEALTH DEPARTMENT



17438 COMAL CO. HEALTH DEPARTMENT  
(Date PDF Version Generated: 09/28/2016)

**1 NOTE: The license will expire if not renewed before 11/30/2016. A Pharmacy may not operate with an expired license.**

RENEWAL FEE IF RECEIVED	11/30/2016	FEE EXEMPT
AFTER	11/30/2016	
AFTER	02/28/2017	

**2 Pharmacy Name & Location Address**

COMAL CO. HEALTH DEPARTMENT  
1297 CHURCH HILL DR STE 102  
NEW BRAUNFELS, TX 78130

Pharmacy Tel. Number: (830) 221-1150  
Pharmacy Fax Number: 830-643 0329  
Web Address:  
Email: millsq@co.comal.tx.us

**3 Pharmacy Class: Clinic**

Indicate All Services Provided By This Pharmacy.  
Must Indicate At Least One Type of Service

- |  |   |
|--|---|
| <input type="checkbox"/> 24 Hour Service                 | <input type="checkbox"/> Home Delivery  |
| <input type="checkbox"/> Alternative Visitation Schedule | <input type="checkbox"/> Infusion   |
| <input type="checkbox"/> Closed Door                     | <input type="checkbox"/> Inpatient Prescriptions  |
| <input type="checkbox"/> Compounding Sterile, LOW Risk   | <input type="checkbox"/> Nuclear  |
| <input type="checkbox"/> Compounding Sterile, MED Risk   | <input type="checkbox"/> Outpatient Prescriptions   |
| <input type="checkbox"/> Compounding Sterile, HIGH Risk  | <input type="checkbox"/> Outpatient Surgery   |
| <input type="checkbox"/> Compounding, Non-Sterile        | <input type="checkbox"/> Pharmacist Administered Immunizations                              |
| <input type="checkbox"/> Compounding, Office Use         | <input type="checkbox"/> Shipping Prescriptions Out-of-State                                |
| <input type="checkbox"/> Expanded Formulary              | <input type="checkbox"/> Veterinary Prescriptions   |
|  | <input type="checkbox"/> Other (specify) <u>CLASS D - CLINIC + COUNTY HEALTH DEPARTMENT</u> |

**Pharmacy Type: Public Health**

Indicate Pharmacy Type

- |   |
|---|
| <input type="checkbox"/> Community Independent      |
| <input type="checkbox"/> Community Multi            |
| <input type="checkbox"/> Hospital (Independent)     |
| <input type="checkbox"/> Hospital (Multiple/Chain)  |
| <input type="checkbox"/> Ambulatory Surgical Center |
| <input checked="" type="checkbox"/> Public Health   |
| <input type="checkbox"/> Other (specify) _____      |

**4 Name and Address of Individual Owner, Partnership or Corporation:** **Ownership Type:** Government  
COMAL CO. HEALTH DEPT.

**5 Ownership information for all owners, partners, or managing officers:**  
See attached page.

**6 Name of Pharmacist In Charge:** RUST, DENNIS KEITH  
**License Number:** 21629

**7 Other Pharmacists and Technicians:**  
See attached page.

## Pharmacy Renewal Application

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**Owners: COMAL CO. HEALTH DEPARTMENT**

License Number - If applicable	Title	Name
	OFFICER	DOROTHY OVERMAN, MD
	OFFICER	SHERMAN KRAUSE
	OWNER	COMAL CO. HEALTH DEPT.

**Other Pharmacists and Technicians: COMAL CO. HEALTH DEPARTMENT**

**Pharmacists**

License Number	Last Name	First Name	Middle Name
21629	RUST	DENNIS	KEITH

**Technicians**

License Number	Last Name	First Name	Middle Name
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# Pharmacy Renewal Application

## PHARMACY (FACILITY) RENEWAL APPLICATION FORM Failure to Supply Any Requested Information Will Delay Processing This Application

<b>1</b>	Has the pharmacy, the pharmacy's owner, or any officer or partner (if the pharmacy is owned by a corporation or partnership) been the subject of <u>any</u> professional disciplinary action or are there any such pending actions by a regulatory authority within the last 36 months? (Examples: denial, surrender, revocation, reinstatement, suspension, fine, reprimand, probation, restriction). Include such information for <u>all</u> states, including Texas, and for all regulated professions.	<input type="checkbox"/> YES* <input checked="" type="checkbox"/> NO
*If the answer is "yes" to Question #1, include the name of the Board, licensing or disciplinary authority and the date of the Order, and if applicable, the date of the termination of the condition and/or probation		
<b>2</b>	For any criminal offense, including those pending appeal and those dismissed, has the pharmacy's owner, or any officer or partner (if the pharmacy is owned by a corporation or partnership), within the last 36 months: A. been arrested? B. been charged with a crime but not arrested? C. pled not a contendere? D. pled guilty? E. received deferred adjudication for a misdemeanor? F. received deferred adjudication for a felony? G. been convicted of a misdemeanor? H. been convicted of a felony?	<input type="checkbox"/> YES* <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES* <input checked="" type="checkbox"/> NO
*In answering Questions #2A - H, include all offenses, even those for which you were subject to deferred adjudication. (Examples: assault, theft, theft by check, driving while license suspended, possession of controlled substances, public intoxication, DWI, driving under the influence of drugs).		
<b>3</b>	Has the pharmacy's owner, or any officer or partner (if the pharmacy is owned by a corporation or partnership), been subject to a court ordered probation or confinement as related to any offense within the last 36 months?	<input type="checkbox"/> YES* <input checked="" type="checkbox"/> NO
<b>4</b>	Has the pharmacy's owner, or any officer or partner (if the pharmacy is owned by a corporation or partnership), served time in prison for any offense within the last 36 months?	<input type="checkbox"/> YES* <input checked="" type="checkbox"/> NO
<b>5</b>	Has the pharmacy's owner, or any officer or partner (if the pharmacy is owned by a corporation or partnership), been convicted of a drug or alcohol related offense, or been subject to a deferred adjudication for this offense (Examples: possession of controlled substances, public intoxication, DWI, driving under the influence of drugs) within the last 36 months?	<input type="checkbox"/> YES* <input checked="" type="checkbox"/> NO
*If the answer is "yes" to Questions #3-5, include the name and location of the court, the offense charged, a brief explanation of the offense, the date of action, and, if applicable, the date that probation or confinement ended. Response must indicate the name of the person who was the subject of the disciplinary action.		
<b>6</b>	Is the pharmacy's owner or any other officer or partner a registered sex offender or have ever been required to register as a sex offender in Texas or any other state?	<input type="checkbox"/> YES* <input checked="" type="checkbox"/> NO
If the answer is "yes" to Question #6, provide the date the individual became a registered sex offender and the state in which the individual was registered. If no longer a registered offender, list the date the registration was terminated.		
<b>7</b>	Are the customer service areas of the Pharmacy accessible to disabled persons, as defined by federal law?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
<b>8</b>	Does the Pharmacy provide Spanish translating services for customers?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
<b>9</b>	Does the Pharmacy provide Vietnamese translating services for customers?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
<b>10</b>	Does the Pharmacy provide a Telecommunication Device for the Deaf (TDD) for a person with impairment of hearing, for customers?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
<b>11</b>	Does the Pharmacy provide American Sign Language translating services for a person with impairment of hearing, for customers?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
<b>12</b>	Does the Pharmacy provide AT&T translating services for customers?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
<b>13</b>	Does the Pharmacy provide any other type of translating services for customers other than those mentioned above?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
<b>14</b>	Does the Pharmacy participate in the Texas Medicaid program?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
<b>15</b>	Does the Pharmacy participate in the state child health plan under Chapter 62, Health and Safety Code?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

**ATTEST:** I hereby attest that the foregoing statements, on this form or those on any attachment(s) to this form are to the best of my knowledge true and correct and that they are all given of my free will. I agree that any misstatement(s) or omission(s) as to material facts will constitute violation of and subject me to the penalties set forth in the Texas Pharmacy Act. I agree to comply with the Texas Pharmacy Act and Rules.

**THIS SIGNATURE MUST BE NOTARIZED:**

\_\_\_\_\_  
Signature of Owner / Managing Officer

\_\_\_\_\_  
Date

Subscribed and sworn to before me this \_\_\_\_\_ day  
of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Owner / Managing Officer's Name (Type or Print)

\_\_\_\_\_  
Notary Public