

HOSPITAL, NURSING HOME, CLINIC BASED PHARMACY QUESTIONNAIRE

1. a. Is your intent to be an outpatient community pharmacy open to the public?

Yes_____ No_____

b. Is this a closed pharmacy, i.e. servicing your own patients? Yes_____ No_____

2. Is your pharmacy on the premises of a hospital, clinic or nursing home or at an off-site satellite location?

Yes_____ No_____

If yes, provide the name of the facility and indicate your affiliation with this facility.

3. Is this pharmacy licensed under a different name other than the name of the facility?

Yes_____ No_____

If yes, provide the name: _____

4. Is the pharmacy licensed as a "for-profit" outpatient retail pharmacy?

Yes_____ No_____

5. Please indicate if you will be dispensing to:

o General Public: Yes_____ No_____

o Hospital Yes_____ No_____

o Nursing Home Yes_____ No_____

o Clinic Yes_____ No_____

o Assisted Living Environment Yes_____ No_____

Signature