California State Board of Pharmacy
1625 N. Market Blvd, Suite N219, Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8618
www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

INSTRUCTIONS FOR FILING A HOSPITAL PHARMACY APPLICATION

Inpatient, Outpatient, Exempt (100 beds or fewer)

Please follow these instructions completely. Failure to submit the necessary items will delay the processing of your application. If the number of forms provided is not sufficient, please make photocopies. Please allow approximately 90 days from the time your application packet is complete before calling the Board of Pharmacy.

If you would like notification that the board has received your application, please submit a stamped postcard addressed to yourself.

SUMMARY OF CHECKLIST

Section A	Requirements for all applicants except government owned, Indian tribe owned, non-Indian owned but operating on tribal lands, or change of location. **Note:** All pharmacy change of ownership applications will be considered for temporary permits. Whenever a change of ownership occurs, either a temporary permit will be pursued or operation must stop. In addition to the regular items required for this application, a $175.00 temporary permit fee must also be submitted.
Section B	Forms required for an applicant whose ownership is a partnership
Section C	Forms required for an applicant who is filing as a corporation
Section D	Forms required for an application who is filing as a limited liability company
Section E	Requirements for state, city or county owned hospital
Section F	Requirements for Indian tribe owned clinic
Section G	Requirements for non-Indian owned but operating on tribal lands
Section H	Requirements for exempt hospital (100 beds or fewer)
Section I	Requirements for change of location only (no ownership change)

CHECKLIST FOR FILING A HOSPITAL PHARMACY APPLICATION

Section A All Applicants

[ ] 1. Application (17A-19) and the non-refundable processing fee of $340.

[ ] 2. Ownership form

a. Corporation OR Limited Liability Company (17A-33)
OR
b. Partnership or Individual (17A-34)

[ ] 3. Financial Affidavit in Support of Application (17A-2)
(*Not needed for a change of location or non-profit organization)*

[ ] 4. Approved wholesale credit application or wholesale agreement
(*Not needed for non-profit organization*)

[ ] 5. Copy of the lease agreement

[ ] 6. Seller's Certification for a Pharmacy (17A-8) (If applicable)
This is only required for an application for a change of ownership and it must be submitted by the prospective owner(s).

[ ] 7. Please provide a copy of your hospital acute care license issued by the Department of Health Services.

[ ] 8. If you are a Knox Keene provider, please provide a copy of your current Department of Corporations license.

Section B Partnership

[ ] 1. Each partner must submit:

- Certification of Personnel (17A-11)
- Individual Personal Affidavit (17A-27)
- Individual Financial Affidavit (form 17A-26)
- Copy of *Request for Live Scan Service Form* verifying that your fingerprints have been scanned and all applicable fees have been paid. Please refer to fingerprint instructions on page 7.

[ ] 2. Certification of Personnel (17A-11) for the pharmacist-in-charge or consulting pharmacist

[ ] 3. Signed Partnership Agreement

If the partners are a corporation or a limited liability company (LLC), then complete and provide the same documents required of corporations (see section C).

Section C Corporation

The first line corporation over the pharmacy needs to complete a form 17A-33. Each remaining parent corporation, over the first line corporation, needs to complete a form 17A-33A.

<u>For Profit</u>

For the named corporation on the application, or person(s) who owns an interest in, the corporation named on the application, the following is required:

[ ] 1. Each corporate officer, major shareholder, and director must submit:

- Certification of Personnel (17A-11)
- Individual Personal Affidavit (17A-27)
- Individual Financial Affidavit (form 17A-26)
- Copy of *Request for Live Scan Service Form* verifying that your fingerprints have been scanned and all applicable fees have been paid. Please refer to fingerprint instructions on page 7.

[ ] 2. Certification of Personnel (17A-11) for the pharmacist-in-charge

[ ] 3. Articles of Incorporation **endorsed** by the Secretary of State.

[ ] 4. Statement

a. Statement by domestic stock **endorsed** by the Secretary of State (form S/O-200). An endorsed copy must be requested from the Secretary of State.

OR

b. Statement by Foreign Corporation (form S/O 350) **endorsed** by the California Secretary of State.
This is only required if the named corporation on the application is incorporated outside of California.

[ ] 5. By-laws

Non-Profit

For the named corporation on the application and any corporation that is the parent of, or who owns an interest in, the corporation named on the application, the following is required:

[ ] 1. Statement of nonprofit corporation, **endorsed** by the Secretary of State.

[ ] 2. By-laws

[ ] 3. Articles of Incorporation **endorsed** by the Secretary of State.

[ ] 4. Each corporate officer, shareholder, and director must submit:

- Certification of Personnel (17A-11)

[ ] 5. Certification of Personnel (17A-11) for the pharmacist-in-charge

Publicly Traded Corporation

[ ] 1. A copy of the corporation's 10K filing with the Securities Exchange Commission.

[ ] 2. A list of the five largest shareholders who own 5% or more of stock which requires a filing with the Securities Exchange Commission.

If the shareholder is an individual, include name, title and professional license (if applicable). Also, identify if the shareholder is a bank, trust company or financial institution to which a license is issued in a fiduciary capacity.

Section D Limited Liability Company (LLC)

In addition to items listed in Section A, the following must be submitted:

The first line limited liability company over the pharmacy needs to complete a form 17A-33A. Each remaining company over the first line limited liability company also needs to complete a form 17A-33A.

[ ] 1. Each member/manager must submit:

- Certification of Personnel (17A-11)
- Individual Personal Affidavit (17A-27)
- Individual Financial Affidavit (form 17A-26)
- Copy of *Request for Live Scan Service Form* verifying that your fingerprints have been scanned and all applicable fees have been paid. Please refer to fingerprint instructions on page 7.

[ ] 2. Certification of Personnel (17A-11 for the pharmacist-in-charge)

[ ] 3. Articles of Organization **endorsed** by the Secretary of State

[ ] 4. Statement of Information endorsed by the Secretary of State

Section E State, City or County Owned Hospital pharmacy

[ ] 1. Application (17A-19)

[ ] 2. Completed Certification of Personnel (17A-11) for:

a. Administrator
b. pharmacist-in-charge

[ ] 3. A letter of verification from the county public health department and the board of supervisors indicating that the facility is government owned

[ ] 4. The name of the Director of Public Health or the responsible party for the hospital pharmacy operation

[ ] 5. A copy of the organizational structure

Correctional facilities/city or county owned jail facilities

[ ] 1. Application (17A-19)

[ ] 2. Completed Certification of Personnel (17A-11) for:

a. warden
b. medical director
c. pharmacist-in-charge

Section F Indian Owned

[ ] 1. Application (17A-19) and the non-refundable processing fee of $340.

[ ] 2. Official documents from the U.S. Department of Interior, Bureau of Indian Affairs, identifying the official tribe.

[ ] 3. A copy of the constitution and by-laws establishing the tribal council that will be the governing entity of the hospital pharmacy.

[ ] 4. Tribal council members and the administrator/CEO must submit:

- Certification of Personnel (17A-11)
- Copy of *Request for Live Scan Service Form* verifying fingerprints for the tribal council and the administrator/CEO have been scanned and all applicable fees have been paid. Please refer to fingerprint instructions on page 7.

[ ] 5. Certification of Personnel (17A-11) for the pharmacist-in-charge.

Section G Non-Indian Owned but Operating on Tribal Lands

If the non-Indian owner is a corporation:

[ ] 1. All requirements listed in Section A.

[ ] 2. Articles of incorporation endorsed by the Indian tribe.

[ ] 3. Statement by domestic stock endorsed by the Indian tribe.

[ ] 4. **AND all other requirements** of corporate owners listed in section D, (except the articles of incorporation and the statement by domestic stock must be endorsed by the Indian tribe and not by the Secretary of State).

If the non-Indian owner is a partnership:

[ ] 1. All requirements listed in Section A.

[ ] 2. Documents describing the agreements with the Indian tribe to operate the hospital pharmacy on tribal land.

[ ] 3. **AND all other requirements** of sole owners or partnership listed in Section B or Section C respectively.

Section H - Exempt Hospitals (100 beds or fewer)

[ ] 1. All requirements listed in Section A.

[ ] 2. All requirements listed in Sections B or C, depending on type of ownership.

[ ] 3. The medical director and the administrator must submit:

- Certification of Personnel (17A-11)
- Copy of *Request for Live Scan Service Form* verifying fingerprints for the medical director and the administrator have been scanned and all applicable fees have been paid. Please refer to fingerprint instructions on page 7.

Section I Change of Location ONLY (no ownership change)

[ ] 1. Application (17A-19) and the non-refundable processing fee of $60.

[ ] 2. Ownership

a. Corporation or Limited Liability Company (17A-33)

OR

b. Partnership or Individual (17A-34)

[ ] 3. Copy of the lease agreement.

[ ] 4. Each corporate officer, shareholder, and director must submit

a. Certification of Personnel (17A-11)
b. Individual Personal Affidavit (17A-27)
c. Completed fingerprint card and $24 fingerprint processing fee.**

[ ] 5. Pharmacist-in-charge must submit a Certification of Personnel (17A-11)

[ ] 6. Please provide a copy of your hospital acute care license issued by the Department of Health Services.

[ ] 7. If you are a Knox Keene provider, please provide a copy of your current Department of Corporations license.

See ownership section for specific requirements, section B-D

** Effective January 1, 2001, the Board of Pharmacy requires all applicants for a new license to have not only a California Department of Justice (DOJ) criminal record check but also a federal background check. **No license will be issued without background clearances from both agencies.**

In order to complete the federal criminal record check, each owner, partner, corporate officer, major shareholder or director must submit rolled fingerprints on cards provided by the board and include a separate fee of $24. You may contact the board to request fingerprint cards at (916) 574-7900. You may also request cards on our website at www.pharmacy.ca.gov.

Fingerprints should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take approximately six weeks. Poor quality prints may result in rejection and will substantially delay licensing as additional fingerprint cards will be required from you for processing.

Fingerprint Requirements

California Residents

The board will only accept Live Scan Service Forms from California residents.

Complete a Live Scan Request form and take all 3 copies to a Live Scan site for fingerprint scanning. Please refer to the Instructions for completing a "Request for Live Scan Service" form. Live Scan sites are located throughout California. For more information about locating a Live Scan site, visit the Department of Justice website at http://ag.ca.gov/fingerprints/publications/contact.htm or the sources listed on the bottom of the instructions for completing a "Request for Live Scan Service" form.

The lower portion of the Live Scan Request form must be completed by the Live Scan operator verifying that your prints have been scanned and all applicable fees have been paid. Attach the second copy of the form to your application and submit to the board.

Non California Residents

If an owner, partner, corporate officer, major shareholder or director reside out of state they must submit rolled fingerprints on cards provided by the board and include a separate fee of $66 ($32 California Department of Justice (DOJ) fee, $10 DOJ expedite fee and $24 FBI fingerprint processing fee). (Live Scan processing fees are paid directly at the Live Scan site.) You may contact the board to request fingerprint cards at (916) 574-7900. You may also request cards on our website at www.pharmacy.ca.gov.

Fingerprints submitted on cards should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take approximately six weeks (live scan is faster). Poor quality prints may result in rejection and will substantially delay licensing as additional fingerprint cards will be required from you for processing.

The board will only accept fingerprint cards from residents outside of California.

17A-46 (Rev.6/04)

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HOSPITAL PHARMACY PERMIT APPLICATION

Inpatient, Outpatient, Exempt (100 beds or fewer)

Please type or print **All blanks must be completed; if not applicable enter N/A**

Name of hospital:	Hospital telephone number:

Address of hospital: Number and Street City State Zip Code

Mailing address: (if different from above) Number and Street City State Zip Code

Type of pharmacy: ☐ Inpatient ☐ Outpatient (check all that apply) ☐ Exempt (100 beds or fewer)

____Retail
____Home Health Care
____Skilled Nursing Facility

This application is for: ☐ New Pharmacy ☐ Change of Location of an existing pharmacy ☐ Change of Ownership of an existing pharmacy

If change of ownership or change of location, indicate previous name, address and license number

Name:	Address:	License Number:

Type of Ownership: ☐ Individual ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Government

___Not-for-profit

Is the pharmacy located at the primary hospital address? ☐ Yes ☐ No

If No, please provide the address of the hospital:

Other areas of the hospital where drugs are stored: (Check all that apply)

☐ Nursing Station ☐ Satellite pharmacy ☐ Drug/Night Locker ☐ Emergency Room ☐ Other:

Continue on Reverse

For office use only			
Staff Review			**Cashiering**
☐ Articles of Incorp ☐ Partner Agreement ☐ Seller's cert ☐ Dep. Corp Lic	☐ Financial Aff ☐ Domestic Stock ☐ By-laws	Approved _____ Denied _____ Date _____	Cashier # _____ Date _____ Amount of fee _____

Department of Health Services license number:	Number of beds : (exempt hospitals only)

Is the pharmacy operated by the hospital? ☐ Yes ☐ No

If No, please provide the name, address and telephone number of management company:

Name of management company	Address:	Telephone number:	Contact person:

Were you qualified as a Knox-Keene provider before August 1, 1981? ☐ Yes ☐ No

If yes, please provide a copy of your current license from the Department of Corporations (Section 4111(d))

Are the pharmacy premises leased, rented or occupied under any agreement with any person who is licensed in California to prescribe? ☐ Yes ☐ No

Will this pharmacy dispense replacement contact lenses to patients? ☐ Yes ☐ No

By your affirmative answer above, your hospital pharmacy name will be provided to the California Medical Board and you will be in compliance with section 4124 of the California Business and Professions Code.

Anticipated first day of business:

Name of contact person:

Name of pharmacist-in-charge:

Address of pharmacist-in-charge: Number & Street City State Zip Code

Exempt Hospital Only

Do you employ a full-time registered pharmacist? ☐ Yes ☐ No

If yes, provide name of pharmacist: License number:

If no, provide name of consulting pharmacist:	License number:

Residence address of consulting pharmacist:

Name of Medical Director:	License number:

Residense address: Number & Street City State Zip Code

Name of Administrator:

Residence address: Number & Street City State Zip Code

Continue on next page

PLEASE READ CAREFULLY AND SIGN BELOW

This application must be approved by the California State Board of Pharmacy before a pharmacy permit will be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. **Any application not completed within 60 days of receipt may be deemed withdrawn by the Board of Pharmacy. Fees applied to this application are not transferable and are not refundable.**

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of a license, and is a violation of the Penal Code of California. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

The information will be used to determine qualifications for licensure under California Pharmacy Law. The officer responsible for information maintenance is the executive officer, (916) 574-7900, 1625 N. Market Blvd, Suite N219, Sacramento, California 95834. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by section 1798.3 of the Civil Code.

ALL OWNERS AND OFFICERS MUST SIGN BELOW

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an officer of the applicant corporation named in the foregoing application, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) no person other than the applicant or applicants has any direct or indirect interest in the applicant(s) business to be conducted under the license(s) for which this application is made; (4) all supplemental statements are true and accurate; and (5) the transfer application may be withdrawn by either the applicant or the licensee with no resulting liability to the Board of Pharmacy.

Inpatient and Outpatient Hospitals (100 beds or more)

Signature of Corporate Officer or Owner	Print Name	Date
Signature of Corporate Officer or Owner	Print Name	Date
Signature of Corporate Officer or Owner	Print Name	Date
Signature of Corporate Officer or Owner	Print Name	Date

Exempt Hospitals Only (100 beds or fewer)

Signature of Administrator	Print Name	Date
Signature of Pharmacist-in-Charge	Print Name	Date

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Partnership or Individual Ownership Information

Please print or type **ALL BLANKS MUST BE COMPLETED; IF NOT APPLICABLE, ENTER N/A**

Name of premises:	Telephone number ( )
Address of premises: Number and Street City State Zip Code	

A. Partnership

If any of the partners listed below is a corporation or limited liability company, form 17A-33 must also be completed for each such entity. Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist, veterinarian, etc., and the license number.

Federal Employer ID Number:* [ ][ ] [ ][ ][ ][ ][ ][ ][ ]

Name or corporate name		Percentage owned %
Residence or corporate address		*Social security number
Licensed as	License number	States licensed in

Name or corporate name		Percentage owned %
Residence or corporate address		*Social security number
Licensed as	License number	States licensed in

Name or corporate name		Percentage owned %
Residence or corporate address		*Social security number
Licensed as	License number	States licensed in

B. Individual owner

Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian; and the license number.

Name		Do you own 100% of business? Yes ☐ No ☐
Residence address		*Social security number
Licensed as	License number	States licensed in

PLEASE READ CAREFULLY. ALL PARTNERS/OWNERS MUST SIGN BELOW.

This application must be approved by the California State Board of Pharmacy before a pharmacy permit can be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. **Fees applied to this application are not transferable and are not refundable.**

Any material misrepresentation in a response to any question is grounds for refusal or subsequent revocation of license, and is a violation of the Penal Code. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

The information will be used to determine qualifications for licensure under the California Pharmacy Law. The officer responsible for information maintenance is the executive officer, (916) 574-7900, 1625 N. Market Blvd, Suite N219, Sacramento, California 95834. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by section 1798.3 of the Civil Code.

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an officer of the applicant corporation named in the foregoing application, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) no person other than the applicant or applicants has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license(s) for which this application is made; (4) all supplemental statements are true and accurate; and (5) the transfer application may be withdrawn by either the applicant or the licensee with no resulting liability to the Board of Pharmacy.

Signature of partner or individual owner	Name (please print)	Date
Signature of partner or individual owner	Name (please print)	Date
Signature of partner or individual owner	Name (please print)	Date

*Disclosure of your social security number (or federal employer identification number ["FEIN"], if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405[c][2][C]) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgement or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number or your FEIN, your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

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Parent Corporation or Limited Liability Company Ownership Information

Please print or type **All blanks must be completed; if not applicable, enter N/A**

Name of parent corporation or limited liability company				Telephone number ( )
Address	Number and Street	City	State	Zip Code
Name & address of premises	Number and Street	City	State	Zip Code

Is the parent corporation a subsidiary? Yes No
If yes, name of parent corporation _____ . This parent corporation must also complete a Parent Corporation or Limited Liability Company Ownership information form. Please attach an organization chart.

A. Limited Liability Members or Manager(s) (Use additional sheets if necessary)

Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc., and the license number (if applicable). Non-profit organizations must list the names and titles of persons holding corporate positions.

Title	Name	Residence address & telephone number	Licensed as, license no. and state(s)

For Limited Liability Companies Only: We, the undersigned members, authorize _____
(Name of member)
to sign all Board of Pharmacy forms, documents and operating conditions on our behalf.

B. Corporate Officers/Directors (Top 5 of each. Use additional sheets if necessary.)

Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc., and the license number (if applicable). Non-profit organizations must list the names and titles of persons holding corporate positions.

Title	Name	Residence address & telephone number	Licensed as, license no. and state(s)

C. Owners/Shareholders

List all persons who own an interest (use additional sheets if necessary). List certificates chronologically, including active, cancelled, and pending issuance. If stock is pledged, include date, number of shares, and from whom to whom. Attach a copy of all stock certificates, transfer ledgers, and proof of purchase issued to date. Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc., and the license number (if applicable).

To whom issued	Residence address & telephone number	Licensed as, license no. and state(s) licensed in	Cert #	% of Shares	Date Issued	Date cancelled

D. Ownership

If no stockholders exist, list all persons with a beneficial interest below.

Name	Residence address & telephone number

E. Does 10% or more of the ownership rest with any other entity? Yes No

If yes, please list below

Name	Residence address & telephone number

This application must be approved by the California State Board of Pharmacy before a permit will be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. Fees applied to this application are not transferable and are not refundable.

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of a license, and is a violation of the Penal Code of California. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

The information will be used to determine qualifications for licensure under California Pharmacy Law. The officer responsible for information maintenance is the executive officer, (916) 574-7900, 1625 N. Market Blvd, Suite N219, Sacramento, California 95834. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him or her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by section 1798.3 of the Civil Code.

ALL OWNERS AND OFFICERS DESIGNATED ON THIS FORM MUST SIGN BELOW.

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an officer of the corporation or limited liability company named on this application form, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) no person other than the applicant or applicants has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license for which this application is made; and (4) all supplemental statements are true and accurate.

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

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Corporation Ownership Information

Please print or type **All blanks must be completed; if not applicable, enter N/A**

Name of parent corporation:				Telephone number ( )
Address of parent corporation:	Number and Street	City	State	Zip Code
Name of applicant premises:				
Address of applicant premises:	Number and Street	City	State	Zip Code

Is the applicant corporation a subsidiary? **Yes** **No**
If yes, name of parent corporation _____. This parent corporation must complete a Parent Corporation or Limited Liability Company Ownership information form. Attach a diagram of the corporate structure showing the subsidiaries.

A. Corporate Officers/Directors (Top 5 of each.)

Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc., and the license number (if applicable). Non-profit organizations must list the names and titles of persons holding corporate positions.

Title	Name	Residence address & telephone number	Licensed as, license no. and state(s)

B. Owners/Shareholders

List all persons who own an interest in this corporation. If more than 5 shareholders, list the 5 largest (use additional sheets if necessary). List certificates chronologically, including active, cancelled, and pending issuance. If stock is pledged, include date, number of shares, and from whom to whom. Attach a copy of all stock certificates, transfer ledgers, and proof of purchase issued to date. Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc., and the license number (if applicable).

To whom issued	Residence address & telephone number	Licensed as, license no. and state(s) licensed in	Cert #	% of Shares	Date Issued	Date cancelled

C. Ownership

If no stockholders exist, list all persons with a beneficial interest below.

Name	Residence address & telephone number

D. Does 10% or more of the ownership rest with any other entity? Yes No If yes, please list below

Name	Residence address & telephone number

This application must be approved by the California State Board of Pharmacy before a permit will be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. Fees applied to this application are not transferable and are not refundable.

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of a license, and is a violation of the Penal Code of California. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

The information will be used to determine qualifications for licensure under California Pharmacy Law. The officer responsible for information maintenance is the executive officer, (916) 574-7900, 1625 N. Market Blvd, Suite N219, Sacramento, California 95834. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him or her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by section 1798.3 of the Civil Code.

ALL OWNERS AND OFFICERS DESIGNATED ON THIS FORM MUST SIGN BELOW.

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an officer of the corporation or limited liability company named on this application form, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) no person other than the applicant or applicants has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license for which this application is made; and (4) all supplemental statements are true and accurate.

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

Print Name_____ Signature _____Date _____

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Fax (916) 574-8618
www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

SELLER'S CERTIFICATION

INSTRUCTIONS: This form is to be completed by the seller and submitted by the prospective owner with the application for a change of ownership. Attach a copy of the pending purchase agreement.

NOTICE: The current permit is not transferable and the current owner of record must maintain operations and control of the licensed premises (including renewing the permit) until a new application is approved by the Board of Pharmacy. The new owner must complete and attach the new application to this document. (Proof of authority to sell by any person, except a person whose name appears on the original permit, must accompany this certification.)

(Please print or type) **All blanks must be completed; if not applicable enter N/A**

This will certify that _____
(name of individual, partnership* or corporation – "seller")

has agreed that on _____ "seller" shall transfer _____
month/day/year (all, half, etc.)

of the right, title and interest in _____ _____
(name of premises) (permit number)

located at_____
(street number and name) (city) (state) (zip code)

To _____
(name of buyer(s))

*IF A PARTNERSHIP, LIST THE NAMES OF ALL PARTNERS (all names must be listed)

On completion of this sale and approval of the new permit, the original permit, and the current renewal must be returned to the California State Board of Pharmacy for cancellation, before the new permit will be released.

Under penalty of perjury under the laws of the State of California, each person whose signature appears below certifies and says that: (1) he/she is the licensee, general partner or an executive officer of the corporate licensee named in this Seller's Certification, duly authorized to make this sale; and (2) all statements made in this Seller's Certification are true and correct to the best of his/her knowledge. If the seller is a partnership, all partners must sign below.

Signature of Seller	Name (please print)	Title	Date
Signature of Seller	Name (please print)	Title	Date
Signature of Seller	Name (please print)	Title	Date

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STATE AND CONSUMER SERVICES AGENCY
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ARNOLD SCHWARZENEGGER, GOVERNOR

CERTIFICATION OF PERSONNEL

INSTRUCTIONS: **Must be completed by each owner, director, officer, major shareholder and pharmacist-in-charge.** All blanks must be completed; if not applicable, enter N/A. Failure to furnish a complete explanation or any omissions **will delay** the processing of your application.

1. Full name (last, first, middle)	
2. Residence address (street, city, state, zip code)	Residence telephone number ( )

3. Are you currently licensed as a physician, podiatrist, dentist, optometrist or veterinarian in this state or any other state? If the answer is "yes," please list each license number, license type, and the state(s) where you are licensed. ☐ Yes ☐ No

License Type	License Number	State	Expiration Date

4. Is your spouse, child, parent, or other relative or any person with whom you share a financial interest, licensed in this state or any other state, as a physician, podiatrist, dentist, or veterinarian? If the answer is "yes," list the name of each person, their relationship to you, the license type, number and state. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name	Relationship	License Type	License Number	State

5. Are you currently, or have you previously been, listed as a corporate officer, partner, owner, manager, limited liability company member, administrator or medical director on a permit to sell, store or possess dangerous drugs or dangerous devices in this state or any other state? If "yes," please list the company name, permit type and number, position(s) held, state and expiration date. Please include information regarding cancelled permits. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name of company	Type of permit	Permit number	Position held	State	Expiration date

6. Have you ever had a pharmacy permit, or any professional or vocational license or registration denied, suspended, revoked, placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state? If "yes," please provide permit type, action, company name (if applicable), year of action and state. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name of person or business	Type of permit	Type of Action	Year of Action	State

7. Are you currently, or have you previously been, associated in business with any person, partnership, corporation, or other entity, or shared a financial or community property interest with any person whose pharmacy permit, or any professional or vocational license was denied, suspended, revoked, or placed on probation or other disciplinary action taken, by this or any other governmental authority in this state or any other state? If the answer is "yes," please list the company name, permit type, action, year of action and state. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name of person or business	Type of permit	Type of Action	Year of Action	State

8. Have you ever been in violation of any provisions of pharmacy law, in this or any other state? If "yes," please list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.) ☐ Yes ☐ No

Name of person or business	Type of permit	Type of Action	Year of Action	State

9. Have you ever been convicted of, or pled no contest to, a violation of any law of a foreign country, the United States, any state or local jurisdiction? You must include all misdemeanor and felony convictions, regardless of the age of the conviction, including those which have been set aside and/or dismissed under Penal Code section 1000 or 1203.4. (Traffic violations of $500 or less need not be reported.) If "yes," please attach an explanation which must include the type of violation, the date, circumstances and location, and the complete penalty received. ☐ Yes ☐ No

10. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety without exposing others to significant health and safety risks? ☐ Yes ☐ No

If “yes,” attach a statement of explanation. If “no,” go directly to question 12.

11. Are the limitations caused by your medical condition reduced or improved because you receive ongoing treatment or participate in a monitoring program? ☐ Yes ☐ No
If "yes," please attach a statement of explanation.

(If you do receive ongoing treatment or participate in a monitoring program, the board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, or whether conditions should be imposed).

12. Do you currently engage in, or have been engaged in the past two years, in the illegal use of controlled substances? ☐ Yes ☐ No
If " yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to ensure that you are not engaging in the illegal use of controlled substances? **Please attach a statement of explanation.**

13. Will you work as an employee of this business? If yes, what will your responsibilities and duties be with this business? ☐ Yes ☐ No

_____

You must provide a written explanation for all affirmative answers to questions 3 - 12. Failure to do so may result in this application being deemed withdrawn as incomplete.

If you are a non-pharmacist owner, partner, corporate officer, corporate director or administrator of the business, you should be aware that:

(a) any non-pharmacist owner who commits any act which would subvert or tends to subvert the efforts of the pharmacist-in-charge to comply with the laws governing the operation of the pharmacy is guilty of a misdemeanor;

(b) you may not order a pharmacist to perform any act which is prohibited by law;

(c) any violation of the Federal Food, Drug & Cosmetic Act, the Federal Controlled Substance Act or any law or regulation relating to the practice of pharmacy in the State of California is grounds for suspension or revocation of the permit for which you are applying;

(d) committing any act prohibited by law, or neglecting to perform any duty required by law, could result in proceedings against the personal license of a pharmacist or could result in an action against your permit.

(e) you are not permitted to assist in any phase of compounding or dispensing of prescriptions, or to perform any of the duties which are required by law or regulation to be done by a pharmacist;

(f) only a pharmacist may possess the key to the pharmacy or to the permanent barrier separating the pharmacy;

(g) you may enter the pharmacy for the purpose of performing certain specified duties only when the pharmacist is present; and the pharmacist is responsible for any non-registered person allowed to enter the pharmacy. (This does not apply to hospital pharmacies or limited permits under Business and Professions Code section 4117, or Title 16, California Code of Regulations section 1714);

(h) dangerous drugs and/or devices as defined in Business and Professions Code sections 4022 and 4023 may only be sold on prescription or to persons who are licensed to handle, sell and possess such drugs.

All items of information requested on this form are mandatory. Failure to provide any of the requested information will result in the application being deemed withdrawn as incomplete. This information will be used to determine qualifications for licensure under California pharmacy law. The officer responsible for information maintenance is the executive officer, telephone (916) 574-7900, 1625 N. Market Blvd Suite N219, Sacramento, California 95834. This information may be transferred to another governmental agency, such as a law enforcement agency, if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by Civil Code section 1798.3.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing certification of personnel form, including all supplementary statements ,and I personally completed this certification of personnel form.

I also certify that I have read and understand the rules of professional conduct and have retained a copy on file.

_____ _____

Signature Date

17A-11 (Rev. 10/00)

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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

Financial Affidavit in Support of Application

All items of information in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information will be used to determine qualifications for registration under the California Pharmacy Law. The official responsible for information maintenance is the executive officer, (916) 574-7900, 1625 N. Market Blvd, Suite N219, Sacramento, California 95834. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on them by our agency, unless the records are identified as confidential information and exempted by section 1798.3 of the Civil Code.

Please print or type **All blanks must be completed; if not applicable, enter N/A**

Name of Corporation, Partnership or Individual Owner:				
Address of Corporation, Partnership or Individual Owner:				
Name of Pharmacy, Hospital, Wholesaler, etc:				
Premises Address:	Number and Street	City	Zip Code	Telephone Number:

Indicate what part of the total investment will be in cash, and from what source(s) it will be or has been derived. **Please attach documentation.** $_____

Source: _____

_____

_____

List all other sources of funding for the pharmacy and how it will be paid. Provide the name, address, telephone number and amount. Use additional sheets if necessary. $ _____

Source: _____

_____

_____

If the pharmacy is franchised, list the name of franchisor:

Who will be the **primary** wholesaler for dangerous drugs and/or dangerous devices? Please attach a photocopy of the **approved** application filed with the wholesaler.				
Name of primary Wholesaler				Telephone number
Address of Wholesaler	Number & Street	City	State	Zip Code

Who will be the **secondary** wholesaler for dangerous drugs and/or dangerous devices? Please attach a photocopy of the **approved** application filed with the wholesaler.				
Name of secondary Wholesaler				Telephone number
Address of Wholesaler	Number & Street	City	State	Zip Code

Business Bank Name & Address (list all accounts for the pharmacy)	Telephone Number	Account Number	Balance of Account
Please submit a copy of most recent bank statement for each bank account listed above.			

List all individuals authorized to sign on business bank account.

Signature	Name (please print)	Title

Name of bookkeeper/accountant for applicant premises:				Telephone Number ( )
Address of bookkeeper/accountant:	Number and Street	City	State	Zip Code

Estimated annual gross sales $_____	Estimated annual purchases $_____

APPLICANT(S) AUTHORIZATION FOR DISCLOSURE OF FINANCIAL RECORDS

For a period of nine months, from this date, for the purpose of authorizing the Board of Pharmacy to conduct an investigation on my/our qualifications pursuant to section 4207 of the Business and Professions Code, I/we hereby authorize the Board of Pharmacy, or any of its authorized personnel to examine and secure copies of financial records consisting of signature cards, checking and savings accounts, notes and loan documents, deposit and withdrawal records, and escrow documents of my/our financial institution(s) or any financial records established in connection with this business.

I/we also authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of any business records or documents established in connection with this business, including, but not limited to, those on file with my/our bookkeeper/accountant or with the escrow holder. I/we agree to furnish current financial information on the annual renewal if requested by the Board of Pharmacy. Applicant understands that falsification of the information on this form may constitute grounds for denial or revocation of the license.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing application, including all supplementary statements.

If corporation owned, one corporate officer must sign; if partnership owned, all partners must sign.

Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date

Date	Place	Attest (Notary Public)

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STATE AND CONSUMER SERVICES AGENCY
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INDIVIDUAL PERSONAL AFFIDAVIT

Please print or type **All blanks must be completed; if not applicable enter N/A**

Full name: Last	First	Middle		
Previous name(s) – include maiden name, also known as (AKA's), "aliases":				Attach a photograph taken within 60 days of the filing of this affidavit
Residence address: Number and Street	City	State	Zip Code	
Date of birth (month/day/year)	Place of birth (city, state, country)			
Driver's license no & state issued in	*Social Security number			**NO POLAROID**
Home telephone:	Current work telephone:			
Name of applicant premises:	Number and Street	City	State	Zip Code
Address of applicant premises:				
Premises telephone:				

I am (Check all that apply)

☐ Sole owner ☐ Officer ☐ General partner ☐ Financier/lender Other - Specify:
☐ Partner ☐ Director ☐ Stockholder _____% ☐ Member (LLC only) _____

Spouse's name (Include alias or maiden) Last	First	Middle
Spouse's social security number	Spouse's Date of Birth	Will your spouse work in any capacity under the permit? Yes ☐ No ☐

Do you have, or have you had, any direct or indirect beneficial interest in any other premises licensed by any board of pharmacy? Include sites licensed in states other than California.

Yes ☐ No ☐

If yes, list current direct or indirect beneficial interests (use an additional sheet if necessary).

Name	Address	Permit Number
Name	Address	Permit Number
Name	Address	Permit Number

If yes, list past direct or indirect beneficial interests during the last five years (use additional sheet if necessary):

Name	Address	Permit Number
Name	Address	Permit Number

Have you -- as an owner, shareholder, officer, member, director or partner -- been involved with a pharmacy, drug wholesaler, medical device retailer, hypodermic permit or out-of-state distributor whose license has been disciplined or an offer in compromise accepted or rejected by a state board of pharmacy or federal regulatory agency? Have you as an individual held a pharmacist license, pharmacy technician registration or exemption certificate that has been disciplined or an offer in compromise accepted or rejected by a state board of pharmacy or federal regulatory agency? Also describe if any of the above actions have occurred with your spouse or palimony partner, or an associate with whom you have shared any ownership interest. Describe the event, regulatory agency involved and date for each incident. (If yes, explain. Use additional sheets if necessary)

Yes ☐ No ☐

Have you as an individual ever been issued any professional or vocational license such as a medical doctor, attorney, dentist, contractor, etc. that has been disciplined by a state regulatory board? (If yes, explain.)

Yes ☐ No ☐

Current and past employment for at least the past five years. (Use additional sheets if necessary).

From (mo/yr)	To (mo/yr)	Type of Work	Firm name and city

Please read carefully and sign below.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license. I hereby authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of financial records consisting of signature cards, checking and savings accounts, note and loan documents, deposit and withdrawal records, and escrow documents of my financial institution(s) or any financial records established in connection with this business. This authorization to examine records at any financial institution may be at any time. I also authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of any business records or documents established in connection with this business including, but not limited to those on file with my bookkeeper.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing individual personal affidavit, including all supplementary statements and I personally completed this personal affidavit.

Applicant Signature Title Date

Place Attest (Notary Public

Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes of compliance with any judgement or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code, or for verification of examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

17A-27 (1/99)

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Individual Financial Affidavit

Please print or type **All blanks must be completed; if not applicable, enter N/A**

Full Name: Last First Middle	Telephone number ( )
Residence Address Number and Street City State Zip Code	
Premises Address Number and Street City State Zip Code	Telephone number ( )

You must indicate one or more of the following:

- ☐ I am making a contribution: total amount $_____ cash amount $_____
- ☐ I am contributing labor/expertise only valued at: $_____
- ☐ I am receiving a loan: total amount $_____ (please attach copy of loan agreement)
- ☐ I am making a loan: total amount $_____ (please attach copy of loan agreement)
- ☐ I am not making a contribution in any form.

SOURCE OF FUNDS USED TO FINANCE BUSINESS

INSTRUCTIONS: Fully explain the source of your financial contributions (e.g. stock/bonds, real estate). If cash funds are from savings, indicate where the money was or is kept. If the source is from the sale of property, indicate what was sold, the address (if real estate), the name and address of the buyer, and the net proceeds from the sale. If a loan is involved, show the date, amount, terms, security, name and address of the lender. Describe any other sources of funds such as inheritances or gifts. Documentation may be requested.

SAVINGS **(Please use additional sheets if necessary)**

	ITEM 1	ITEM 2
Financial Institution(s)		
Address		
Amount		
Account Number		
Source of savings		

CHECKING **(Please use additional sheets if necessary)**

	ITEM 1	ITEM 2
Financial Institution(s)		
Address		
Amount		
Account Number		
Source of checking		

LOANS & CREDIT APPLICATIONS FOR THIS BUSINESS **(Please use additional sheets if necessary)**

	ITEM 1	ITEM 2
Date(s)		
Amount(s)		
Term(s)		
Item(s) secured		
Security(s)		
Lender(s)		

SALE OF PROPERTY TO FINANCE THIS BUSINESS **(Please use additional sheets if necessary)**

	ITEM 1	ITEM 2
Type		
Location(s)		
Date sold		
Buyer		
Net proceeds		
Other source(s)		

Will funding be provided in any amount from an individual, partnership or corporation whose professional or vocational license has been revoked, denied or in any other manner disciplined by a regulatory board in California or any other state?

Yes ☐ No ☐

If yes, please explain fully below (attach additional sheets if necessary). Attach copies of all disciplinary orders.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please read and sign below in the presence of a Notary Public.

For a period of nine months from this date and pursuant to section 4207 of the Business and Professions Code, I hereby authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of financial records consisting of signature cards, checking and savings accounts, note and loan documents, deposit and withdrawal records, and escrow documents of my financial institution(s) or any financial records established in connection with this business. This authorization to examine records at any financial institution may occur at any time. I also authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of any business records or documents established in connection with this business including, but not limited to, those on file with my bookkeeper.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing Individual Financial Affidavit, including all supplementary statements and I personally completed this financial affidavit.

Applicant's signature

Title | Date

Place | Attest (Notary Public)

INSTRUCTIONS FOR COMPLETING A "REQUEST FOR LIVE SCAN SERVICE" FORM
(California Residents)

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly; failure to do so may result in processing delays of your application.

1. **Job Title or Type of License, Certification, or Permit:** Enter the type of license, certification or permit for which you are applying. Appropriate license types include pharmacist, pharmacy technician, intern pharmacist, exemptee, or if an owner or officer of a pharmacy, hospital, clinic, wholesaler or hypodermic permit enter appropriate title of the facility.
2. **Name of Applicant:** Enter your last name, first name and middle name. Do not use initials or name abbreviations.
3. **AKA:** Enter all other names you have used, including your maiden name.
4. **CDL No:** Your California Driver's License Number.
5. **DOB:** Your date of birth (month/day/year).
6. **SEX:** Your gender (male or female).
7. **HT:** Your height in feet and inches.
8. **WT:** Your weight in pounds.
9. **Misc. No.:** Enter other identifying numbers. (e.g., Other State Driver's License Number)
10. **EYE Color:** Color of your eyes
11. **HAIR Color:** Color of your hair
12. **Home Address:** Your residence address
13. **POB:** Enter your place of birth.
14. **SOC:** Enter your Social Security Number

Take the completed form to your nearest Live Scan site for fingerprint scanning. There are more than 130 Live Scan sites throughout the state. An up-to-date Live Scan site list is on the Department of Justice's (DOJ) Internet web page at http://ag.ca.gov/fingerprints/publications/contact.htm or call your local police or sheriff's department.

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (DOJ processing fee of $32, FBI processing fee of $24, and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about $5 to $20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs.

The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

FINGERPRINTING AUTHORITY

Section 144(b) of the Business and Professions Code authorizes the Board of Pharmacy to require an applicant for licensure to furnish a full set of fingerprints for purposes of conducting criminal history record checks. Fingerprints are required in order for the DOJ/FBI to conduct background checks for criminal convictions.

17M-15 (9/05)

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071 (Code assigned by DOJ)

Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy - Section 4201

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

1625 N. Market Blvd, Suite N219
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento, CA 95834
City State Zip Code

(916) 574-7900
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____
Date of Birth

SEX: ☐ Male ☐ Female

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____
Height

WT: _____
Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

If resubmission, list Original ATI No. _____

Level of Service DOJ ☑ FBI ☑

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

N/A
( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

ORIGINAL -Live Scan Operator; SECOND COPY-Board of Pharmacy; THIRD COPY-Applicant

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071
Code assigned by DOJ

Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy - Section 4201
(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

1625 N. Market Blvd, Suite N219
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento, CA 95834
City State Zip Code

(916) 574-7900
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____
Date of Birth

SEX: ☐ Male ☐ Female

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____
Height

WT: _____
Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☑

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

N/A
( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

ORIGINAL-Live Scan Operator; SECOND COPY Board of Pharmacy; THIRD COPY-Applicant

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071
Code assigned by DOJ

Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy - Section 4201
(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

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Licensing
Contact Name (Mandatory for all school submissions)

Sacramento, CA 95834
City State Zip Code

(916) 574-7900
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____
Date of Birth

SEX: ☐ Male ☐ Female

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____
Height

WT: _____
Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☑

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

N/A
( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

ORIGINAL-Live Scan Operator; SECOND COPY - Board of Pharmacy; THIRD COPY - Applicant