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 AN APPLICATION FOR HYPODERMIC NEEDLE & SYRINGE PERMIT

Permits cannot be transferred to a new location or to new owners. The board must approve any new location or new owner **BEFORE** the change occurs (allow 60 days). Permits are issued for one year, and must be renewed before expiration. Needle and syringes cannot be sold unless the permit is renewed. Failure to renew the permit within 60 days from the expiration date may result in the permit being cancelled. If, after cancellation, needle and syringe sales are to be resumed, a new application (with all documents) must be submitted.

IMPORTANT

Please follow these instructions completely. You must complete and submit all of the requested information. Failure to submit the necessary items will delay the processing of your application. Forms that have been previously submitted with another application cannot be removed from that file.

If the number of forms provided is not sufficient, please make photocopies. You will be notified of any major deficiencies in your application. Please allow approximately 60 days from the time your application 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.

The following instructions are divided into 5 sections. Section A lists the requirements for all applicants. Sections B through D list what items are needed from different types of applicant ownership.
If you are submitting an application for a change of location go directly to Section E and follow the instructions.

CHECKLIST FOR FILING AN APPLICATION FOR HYPODERMIC NEEDLE AND SYRINGE PERMIT

Section A All Applicants

[ ] 1. Completed application (17A-15) and the non-refundable processing fee of $90.

[ ] 2. Seller's Certification (17A-16) (If applicable)
This is only required for an application for a change of ownership and it must be submitted by the prospective owner(s).

Section B Individual Owner who is not incorporated

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

[ ] 1. The individual owner must submit:

a. Individual Certification Affidavit (17A-37)
b. 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 3.

Section C Partnership

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

[ ] 1. Each partner must submit:

a. Individual Certification Affidavit (17A-37)
b. Copy of *Request for Live Scan Service Form* verifying that fingerprints have been scanned and all applicable fees have been paid. Please refer to fingerprint instructions on page 3.

[ ] 2. Copy of signed Partnership Agreement.

Section D Corporations

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

[ ] 1. Each of the top 5 corporate officers, major shareholders and directors must submit:

a. Individual Certification Affidavit (17A-37)
b. 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 3.

[ ] 2. Copy of Articles of Incorporation **endorsed** by the Secretary of State or the applicable tribal government if business is located on a reservation.

Section E Change of Location ONLY (no ownership change)

[ ] 1. Application (17A-15) and the non-refundable processing fee of $60.

[ ] 2. Each owner, partner or the top 5 corporate officers, shareholders and directors must submit:

a. Individual Certification Affidavit (17A-37)

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 near you, 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) processing fee and $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.

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STATE AND CONSUMERS AFFAIRS AGENCY
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APPLICATION FOR HYPODERMIC NEEDLE AND SYRINGE PERMIT

(Please print or type)

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

Indicate type of ownership:

☐ Individual ☐ Partnership ☐ Corporation ☐ Not-for-profit corporation ☐ Government owned

Indicate whether this application is for:

☐ Change of Location of an existing Business ☐ Change of ownership of an existing Business ☐ New Business

If this is a change of ownership or a change of location, indicate below the previous name, address and license number of Hypodermic Needle and Syringe Permit.

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

Type of business to be conducted at this location:

☐ Veterinary Supply ☐ Other: _____

Hypodermic needle and syringes will be sold or used for what purpose?

_____

Name of responsible managing employee:

Residence address:	City:	State:	Zip Code:

Continue on reverse side

For Office Use Only		
☐ Articles of Incorp ☐ Partnership agreement ☐ Sellers' Cert	Approved _____ Denied _____ Date _____	Cashier # _____ Date _____ Amount_____

Owners/Partners/Corporate Officers (Top 5 of each)			
Title	Name	Residence Address	Telephone number

Premise is: ☐ Leased/rented ☐ Owned

Name of lessor/rentor or owner	Address	City/State/Zip	Telephone number
			( )

Name of lessee/renter	Address	City/State/Zip	Telephone number
			( )

Anticipated first day of business:

Name and telephone number of person authorized to clarify information provided on this application

( )

This application must be approved by the California State Board of Pharmacy before a Hypodermic Needle and Syringe permit will be issued. If changes are made during the application process, you may need to submit a new application with 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 license, and a violation of the Penal Code of California. 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 licensure under the California Pharmacy Law. The official responsible for information maintenance is the Executive Officer, 1625 N. Market Blvd, N219, Saramento, California 95834, (916) 574-7900. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties.

Continue on next page

Certification of Applicant – Please read carefully and sign below

Under penalty of perjury, under the laws of the state of California, each person whose signature appears below, certifies that: (1) He/she is the applicant, or one of the owners or managers of the applicant corporation, named in the foregoing application, duly authorized to make this application on its behalf; (2) that he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) that 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, and (4) all supplemental statements are true and accurate.

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

17A-15 (Rev. 3/06)

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STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
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INDIVIDUAL CERTIFICATION AFFIDAVIT

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.

Please print or type

Full name: Last First Middle	Residence telephone: ( )
Previous name(s) – include maiden name, also known as (AKA's), "aliases":	*Social Security number:
Residence address: Number and Street City State Zip	
Date of birth: (Month, Day, Year)	Place of birth: (City, State, Country)

Name and address of current employer:		
Work telephone:	Present occupation:	Professional or vocational licenses held: (Specify type and number)

Spouse's name: Last First Middle	
Spouse's Date of Birth:	Spouse's Social Security Number:
Will your spouse work in any capacity under the permit? ☐ Yes ☐ No	

Name of applicant premises:	Applicant telephone number:
Address of applicant premises: Number and Street City State Zip	

My position with the applicant is: (Check all that apply)

Sole owner Partner	Officer Stockholder _____%	Director Financier/lender	Manager Other - Specify: _____

1. Do you have, or have you had in the last 5 years, any direct or indirect beneficial interest in any other premises licensed by any board of pharmacy? Yes ☐ No ☐

If yes, list current direct or indirect beneficial interests (use an additional sheet if necessary). Include sites licensed in states other than California.

Name	Address	Permit Number	Dates: From/To
Name	Address	Permit Number	Dates: From/To
Name	Address	Permit Number	Dates: From/To

2. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator or medical director on a permit to conduct a pharmacy, wholesaler, medical device retailer, veterinary retailer or any other entity licensed in this state or any other state?

Yes ☐ No ☐

If the answer is "yes," please list the company name, permit type and number, position(s) held, state and expiration date. Please include cancelled permits. (Use additional sheets if necessary.)

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

3. Have you ever had a permit or any professional or vocational license or registration denied, suspended, revoked, voluntarily surrendered, placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state or by a federal regulatory agency?

Yes ☐ No ☐

If the answer is "yes," please provide company name, permit type, action, year of action and state. (Use additional sheets if necessary.)

Name of person or company	Type of permit	Type of action	Year of action	State

4. Have you ever been in violation of any provisions of pharmacy law? Yes ☐ No ☐

If "yes," please list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.)

Type of violation	License type	Type of action	Year of action	State

5. 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 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 or by a federal regulatory agency?

Yes ☐ No ☐

If the answer is "yes," please list the company name, permit type, action, year of action and state. (Use additional sheets if necessary.)

Name of person or company	Type of permit	Type of action	Year of action	State

6. Please describe if any of the above actions with spouse or an individual with whom you have a personal ownership interest in real property._____

_____

7. Have you ever been convicted of, or pled no contest to, a violation of any law of a foreign country, the United States or of any state or local ordinances? 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 sections 1000 or 1203.4. (Traffic violations of $500 or less need not be reported.)

Yes ☐ No ☐

If "yes," please attach an explanation which must include the type of violation, the date, circumstances and location, and the full penalty received.

8. 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 you marked "no" to question 8, please go directly to question 10.

9. 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).

10. 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 assure that you are not engaging in the illegal use of controlled substances? Please attach a statement of explanation.

11. Will you work as an employee of this business? Yes ☐ No ☐

If yes, what will your responsibilities and duties be with this business? _____

_____

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

From (month/year)	To (month/year)	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 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's signature	
Title	Date
Place	Attest (Notary Public)

*Disclosure of your social security number is mandatory. Business and Professions Code section 30 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.

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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

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: Hypodermic - Section 4205

(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: _____ SEX: ☐ Male ☐ Female
Date of Birth

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

HT: _____ WT: _____
Height 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: _____ Date _____
Name of Operator

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: Hypodermic - Section 4205

(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: Hypodermic - Section 4205

(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