



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

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

INSTRUCTIONS FOR FILING A NONRESIDENT PHARMACY APPLICATION

IMPORTANT: 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. Allow the board 45 days to process your application upon receipt. The designated person reflected in the application will be advised if additional information is necessary.

To assist you with the application process and requirements, a checklist is provided with the application. The board encourages the applicant to refer to the checklist to assist with the application process. The application strongly encourages the applicant to submit all supporting documentation along with the application. It is not uncommon for the board to request additional documentation to confirm or substantiate information contained in the application.

Note: A pharmacy license is nontransferable. An application for a change in ownership or location of a pharmacy must be submitted **PRIOR** to the change occurring. All pharmacy change of ownership applications will be considered for temporary permits. Whenever a change of ownership occurs, either a temporary permit will need to be pursued or operation must stop. If an application is submitted **AFTER** a change of ownership or change of location occurs, until a new license is issued, it is considered a new application.

SUMMARY OF CHECKLIST

- | | |
|-----------|---|
| Section A | Requirements for all applicants except government owned, or Indian tribe owned. |
| Section B | Forms required for an applicant who is filing as an individual owner. |
| Section C | Forms required for an applicant whose ownership is a partnership. |
| Section D | Forms required for an applicant who is filing as a corporation. |
| Section E | Forms required for an applicant who is filing as a limited liability company. |
| Section F | Fingerprint Requirements |

CHECKLIST FOR FILING AN NON-RESIDENT PHARMACY APPLICATION

Section A All Applicants

- [] 1. Application (17A-57)
Complete the entire application and submit with original signatures.
- **Do Not Leave Blanks.** If an item or question is not applicable, indicate N/A.
 - **Doing Business As (DBA):** If using a DBA, submit a Fictitious Name Statement.
 - **Change of Ownership:** Provide all required documents under the appropriate section listed in the instructions, along with the Seller's Certification and a copy of the pending purchase agreement. A copy of the final sale/closing documents will need to be submitted prior to issuance. *A change of ownership requires board approval prior to the sale occurring. All approved change of ownership applications result in a new license number being issued.*
 - **Change of Location ONLY:** *A change of location requires board approval. The license of the current location must be current at the time the board approves the change of location and issues a new license to the new physical location.*
- [] 2. Application Processing Fee \$520
Include a check or money order for \$520 made payable to the Board of Pharmacy. This fee is nonrefundable. (NOTE: A government owned pharmacy is fee exempt.)
- To apply for a temporary license for a change of ownership ONLY, an additional fee of \$325 must be submitted along with the application processing fee of \$520.
- [] 3. Certification of Personnel (17A-11) for the pharmacist-in-charge and two completed fingerprint cards along with a \$49 processing for the pharmacist-in-charge. Please reference Section F for the fingerprint requirements.
- [] 4. Ownership form
- a. Corporation (17A-33)
- OR**
- b. Partnership or Individual (17A-34)
- [] 5. For multiple levels of ownership, submitting an organization chart is helpful to facilitate the board's review.
- [] 6. Financial Affidavit in Support of Application (17A-2)
(Note: *Not needed for a change of location or non-profit organization*)
- [] 7. Approved wholesale credit application or wholesale agreement
(Note: *Not needed for a non-profit organization*)
- [] 8. Provide a copy of the lease agreement if the pharmacy premises is leased
- If the premises is leased, rented or occupied by any person who is licensed in California to prescribe, a statement from the corporate attorney regarding prescriber control must be submitted.
- [] 9. A copy of the last inspection report.
- [] 10. 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).

- [] 11. A statement indicating that you maintain records of controlled substances or dangerous devices dispensed to California patients, so that those records are readily retrievable from other drugs dispensed.
- [] 12. Two prescription labels that include a toll free number that meet the requirements as outlined in Business and Professions Code sections 4076 and 4076.5 and California Code of Regulation section 1707.5.
- [] 13. A list of pharmacists and their license numbers for those who fill prescriptions for California residents with a statement reflecting the nonresident pharmacies shall not permit a pharmacist whose license has been revoked by the board to provide any pharmacy-related services to a person residing in California.
- [] 14. Submit license verification from the home state the pharmacy is located. The state seal must be embossed on the license verification.

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:
 - Certification of Personnel (17A-11)
 - Individual Personal Affidavit (17A-27)
 - Individual Financial Affidavit (17A-26)
 - Two completed fingerprint cards along with a \$49 fingerprint processing fee. Please reference Section F of the application instructions below on the requirements for submitting fingerprints.

Section C Partnership

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

- [] 1. Each partner must submit:
 - Certification of Personnel (17A-11)
 - Individual Personal Affidavit (17A-27)
 - Individual Financial Affidavit (17A-26)
 - Two completed fingerprint cards along with a \$49 fingerprint card processing fee. Please reference Section F of the application instructions below on the requirements for submitting fingerprints.
- [] 2. Signed Partnership Agreement.
- [] 3. Provide the Federal Employer Identification Number (FEIN).

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

Section D Corporations

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

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

For Profit

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 (17A-26)
 - Two completed fingerprint cards along with a \$49 fingerprint card processing fee. Please reference Section F of the application instructions below on the requirements for submitting fingerprints.
- 3. Submit a copy of the Articles of Incorporation showing proof of filing with the Secretary of State.
- 4. Statement of Information: Submit a copy of the filing with the Secretary of State bearing the Secretary of State stamp that discloses the current officers on file for the entity or equivalent governmental document that discloses the current officer(s) on file for the entity.
- 4. Bylaws

Non-Profit

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)
- 2. Submit a copy of the Articles of Incorporation showing proof of filing with the Secretary of State.
- 3. Statement of Information: Submit a copy of the filing with the Secretary of State bearing the Secretary of State stamp that discloses the current officers on file for the entity or equivalent governmental document that discloses the current officer(s) on file for the entity.
- 4. Bylaws

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 E Limited Liability Companies

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-33. 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 (17A-26)
 - Two completed fingerprint cards along with a \$49 fingerprint card processing fee. Please reference Section F of the application instructions below on the requirements for submitting fingerprints.
- [] 2. Submit a copy of the Articles of Organization showing proof of filing with the Secretary of State
- [] 3. Statement of Information: Submit a copy of the filing with the Secretary of State bearing the Secretary of State stamp that discloses the current officers on file for the entity or equivalent governmental document that discloses the current officer(s) on file for the entity.
- [] 4. Provide a copy of the Operating Agreement/Limited Liability Company Agreement.
- [] 5. Provide the Federal Employer Identification Number (FEIN).

Section F Fingerprints (Not required if the applicant business is owned by the state, city or county.)

Each owner, partner, corporate officer, member, major shareholder or director listed on the application is required to complete the Live Scan or fingerprint cards. *If a person is currently associated with an active license and has fingerprints already on file with the California State Board of Pharmacy, new fingerprints may not be required.*

Fingerprint Instructions: Complete and attach **ONE** of the following (either A or B):

- California residents must use Live Scan. Nonresidents can visit California to complete a Live Scan or must submit professionally rolled fingerprints on cards supplied by the board.
- DO NOT complete the Live Scan form prior to fingerprinting or fingerprint cards until the cards are ready to send with the application.
- The Live Scan site may charge a processing fee.
- Fingerprint card processing fee is \$49 per person (\$32 DOJ and \$17 FBI) made payable to the Board of Pharmacy.
- The board will accept fingerprint responses only from the California Department of Justice (DOJ) and Federal Bureau of Investigation (FBI).

A. California Resident: Attach a copy of the completed Live Scan receipt. The receipt verifies the person has completed the Live Scan process and provides tracking information. It is the responsibility of the person being fingerprinted to verify that all personal information entered by the Live Scan operator is correct prior to the operator's submission. The Board of Pharmacy will not accept clearances by the DOJ/FBI if the personal information is incorrect. Receipt of incorrect information by the DOJ/FBI will result in the individual having to complete a new Live Scan.

- California residents must use Live Scan only.
- To find a Live Scan location, go to <https://oag.ca.gov/fingerprints/locations>
- **Type of License/Certification/Permit or Working Title:** Pharmacy – Section 4201

- **Full Name:** Must be EXACTLY THE SAME as the name on your state driver's license or state-issued identification card. (Jr., II, etc., must be included). It must also be EXACTLY THE SAME as the name on your application.
- **Date of Birth:** Must be correct.
- **Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN):** Include your SSN. If left blank you may have to reprint.
- **Level of Service:** Must include both DOJ and FBI.

B. Non-California Resident: The person being fingerprinted may visit California and complete Live Scan. If he/she cannot complete the Live Scan then two rolled fingerprint cards must be submitted to the board for each individual being fingerprinted.

- Only fingerprint cards provided by the Board of Pharmacy will be accepted.
- Request fingerprint cards through the board's online services at https://www.dca.ca.gov/webapps/pharmacy/pubs_request.php or via email to rxforms@dca.ca.gov.
- Fee: Include fingerprint card processing fee of \$49 for each person (\$32 DOJ and \$17 FBI) made payable to the Board of Pharmacy. You may submit one check or money order for both the application processing fee and fingerprint processing fee(s).
- Print legibly or type personal information on the fingerprint cards. If the person's personal information is not legible and DOJ enters the information incorrectly, he/she will be responsible to submit new fingerprint cards and pay the \$49 fingerprint processing fee again. DOJ will NOT correct print results due to illegible fingerprint cards.
- Fingerprints must be taken by a person professionally trained to roll fingerprints.
- Fingerprint clearances from cards take approximately six weeks.
- Poor quality prints will be rejected by DOJ/FBI and will cause delay because new fingerprint cards will be required.

<p>California Department of Justice DIVISION OF CALIFORNIA JUSTICE INFORMATION SERVICES Nick L. Dedier, Director/CIO</p> 	<h1>INFORMATION BULLETIN</h1>	
<p><i>Subject:</i> Out-of-State Applicant Fingerprint Submissions (Supercedes Information Bulletin 03-15-BCIA)</p>	<p><i>No.</i> 05-23-BCIA</p> <hr/> <p><i>Date:</i> 10-24-2005</p>	<p><i>Contact for information:</i> Fingerprint Rolling Certification Program Darlene Towle (916) 227-3249</p>

To: All California Applicant Agencies

The purpose of this Information Bulletin is to advise applicant agencies regarding the submission of fingerprints from out-of-state applicants.

California Penal Code Section 11102.1 precludes the DOJ from accepting applicant fingerprints unless the impressions were rolled by a certified fingerprint roller, or by an individual who is specifically exempt from the certification requirement. Currently, only law enforcement personnel and state employees who have met specified requirements are exempt from the certification requirement. This statute was enacted to protect the integrity of California's criminal history records and guard against fraud by certifying those individuals who roll applicant fingerprint impressions.

In order to meet this mandate and avoid the processing delays and additional costs that result from fingerprint rejects, individuals residing outside of California and applying for employment or licensure in California who cannot be fingerprinted in California must have their fingerprints rolled at a law enforcement agency in their state of residence.

Questions regarding this Information Bulletin should be directed to the Fingerprint Rolling Certification Program at the above telephone number.

Sincerely,



DOUG SMITH, Deputy Director
Division of California Justice Information Services

For: BILL LOCKYER
Attorney General

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NONRESIDENT PHARMACY PERMIT APPLICATION

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

Name of Pharmacy:		Pharmacy Telephone Number ()		
Address of Pharmacy:	Street and Number	City	State	Zip Code
Indicate whether this application is for:				
<input type="checkbox"/> New Pharmacy		<input type="checkbox"/> Change of Location of an existing pharmacy		<input type="checkbox"/> Change of Ownership of an existing pharmacy
If this is a change of ownership or change of location , indicate previous name, address and license number of pharmacy.				
Date of proposed change of ownership or location:				
Please indicate type of ownership:				
<input type="checkbox"/> Individual		<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation	<input type="checkbox"/> Not-for-profit corporation
		<input type="checkbox"/> Limited Liability		
Name of agent for service of process in California			Agent's telephone number ()	
Agent's California address (P.O. box not acceptable)		City	State	Zip Code
Toll-Free Telephone Number for patient-pharmacist communication 1-888 1-800		Resident State pharmacy permit # & date issued		
Do you mail replacement contact lenses to patients in California? Yes <input type="checkbox"/> No <input type="checkbox"/>				
By your affirmative answer above, your 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.				
CONTINUE ON REVERSE				
FOR OFFICE USE ONLY				
STAFF REVIEW			CASHIER LOG	
<input type="checkbox"/> Articles of Incorp	<input type="checkbox"/> Financial Aff	Approved _____	Cashier # _____	
<input type="checkbox"/> Partner agreement	<input type="checkbox"/> Stock Cert	Denied _____	Date _____	
<input type="checkbox"/> Seller's certificate	<input type="checkbox"/> By-laws	Date _____	Amount of fee _____	
<input type="checkbox"/> Whlse agreement	<input type="checkbox"/> Lease			



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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:*

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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 <input type="checkbox"/> No <input type="checkbox"/>
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.

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 _____



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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 _____



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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. 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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 GOVERNOR EDMUND G. BROWN JR.

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:

<p>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. \$ _____</p> <p>Source: _____</p> <p>_____</p> <p>_____</p>
<p>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. \$ _____</p> <p>Source: _____</p> <p>_____</p> <p>_____</p>

<p>If the pharmacy is franchised, list the name of franchisor:</p>
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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
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Address of Wholesaler	Number & Street	City	State	Zip Code
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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
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Address of Wholesaler	Number & Street	City	State	Zip Code
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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 ()
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Address of bookkeeper/accountant:	Number and Street	City	State	Zip Code
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Estimated annual gross sales \$ _____	Estimated annual purchases \$ _____
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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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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

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
 DEPARTMENT OF CONSUMER AFFAIRS
 GOVERNOR EDMUND G. BROWN JR.

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 NO POLAROID		
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				
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) <input type="checkbox"/> Sole owner <input type="checkbox"/> Officer <input type="checkbox"/> General partner <input type="checkbox"/> Financier/lender Other - Specify: _____ <input type="checkbox"/> Partner <input type="checkbox"/> Director <input type="checkbox"/> Stockholder _____% <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>		

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."

NOTICE: Effective July 1, 2012, the State Board of Equalization and the Franchise Tax Board may share individual taxpayer information with the board. You are obligated to pay your state tax obligation. This application may be denied or your license may be suspended if the state tax obligation is not paid.



CERTIFICATION OF PERSONNEL

INSTRUCTIONS: This form must be completed by each owner, director, officer /or major shareholder as well as a Pharmacist-in-Charge of a nonresident pharmacy, where the pharmacist does not hold a current and valid California pharmacist license.

All blanks must be completed; if not applicable, enter N/A. Failure to furnish a complete explanation or any omissions **may delay** the processing of your application.

1. Full name (last, first, middle)	
2. Residence address (street, city, state, zip code)	
3. Residence telephone number ()	4. Email address

5. 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

6. 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

7. 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

8. 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

9. 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

10. 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

Type of Violation	License Number	Type of Action	Year of Action	State

11. Do you have a mental illness or physical illness that in any way impairs or limits your ability to practice your profession with reasonable skill and safety without exposing others to significant health or safety risks? Yes No

If "yes," attach a statement of explanation. If "no," go directly to question 13.

12. Are the limitations caused by your mental illness or physical illness 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, severity and duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or to determine if you are not eligible for licensure.

13. Do you currently engage or have you previously engaged in the illegal use of controlled substances? Yes No

If "yes," are you currently participating in a supervised substance abuse program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled substances? Yes No

Attach a statement of explanation.

If "yes," have you participated in a substance abuse program in the past five years? Yes No

Attach a statement of explanation.

14. Have you ever been convicted of, or pleaded guilty or nolo contendere/no contest to, any crime, in any state, the United States or its territories, a military court, or any foreign country? Include any felony or misdemeanor offense, and any infraction involving drugs or alcohol with a fine of \$500 or more. You must disclose a conviction even if it was:

Yes No

(1) later dismissed or expunged pursuant to Penal Code section 1203.4 et seq., or an equivalent release from penalties and disabilities provision from a non-California jurisdiction, or (2) later dismissed or expunged pursuant to Penal Code section 1210 et seq., or an equivalent post-conviction drug treatment diversion dismissal provision from a non-California jurisdiction. Failure to answer truthfully and completely may result in the denial of your application.

NOTE: You may answer "NO" regarding, and need not disclose, any of the following: (1) criminal matters adjudicated in juvenile court; (2) criminal charges dismissed or expunged pursuant to Penal Code section 1000.4 or an equivalent deferred entry of judgment provision from a non-California jurisdiction; (3) convictions more than two years old on the date you submit your application for violations of California Health and Safety Code section 11357, subdivisions (b), (c), (d), or (e), or California Health and Safety Code section 11360, subdivision (b); and (4) infractions or traffic violations with a fine of less than \$500 that do not involve drugs or alcohol.

You may wish to provide the following information in order to assist in the processing of your application: descriptive explanation of the circumstances surrounding the conviction (i.e. dates and location of incident and all circumstances surrounding the incident). If documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required.

Failure to disclose a disciplinary action or conviction may result in the license being denied or revoked for falsifying the application. Attach additional sheets if necessary.

Arrest Date	Conviction Date	Violation(s)	Case #	Court of Jurisdiction (Full Name and Address)

15. 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 8 - 15. 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, CA 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.

NOTICE: Effective July 1, 2012, the State Board of Equalization and the Franchise Tax Board may share individual taxpayer information with the board. You are obligated to pay your state tax obligation. This application may be denied or your license may be suspended if the state tax obligation is not paid.

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



California State Board of Pharmacy
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BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
 DEPARTMENT OF CONSUMER AFFAIRS
 GOVERNOR EDMUND G. BROWN JR.

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
				()
You must indicate <u>one or more</u> of the following:				
<input type="checkbox"/> I am making a contribution: total amount \$_____ cash amount \$_____				
<input type="checkbox"/> I am contributing labor/expertise only valued at: \$_____				
<input type="checkbox"/> I am receiving a loan: total amount \$_____ (please attach copy of loan agreement)				
<input type="checkbox"/> I am making a loan: total amount \$_____ (please attach copy of loan agreement)				
<input type="checkbox"/> 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)