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 TO OBTAIN A VETERINARY FOOD-ANIMAL DRUG RETAILER LICENSE

A veterinary food-animal drug retailer (vet retailer) is an area, place, or premises, other than a pharmacy, that holds a valid license from the Board of Pharmacy of the State of California as a wholesaler and, in and from which veterinary drugs for food-producing animals are dispensed pursuant to a prescription from a licensed veterinarian.

For each site licensed by the board, there must be:

1. A wholesale drug license for the premises that is specific to the designated address.

2. A vet retailer license that is specific to the same address as the wholesaler.

3. A California-licensed pharmacist or a person who is specially authorized by the board as an exemptee, and who is designated as an exemptee-in charge of the vet retailer site. Exemptees for vet retailers must have specific training in addition to that which is required for wholesale exemptees.

4. At least one California-licensed pharmacist or vet retailer exemptee present during all hours of operation. Note; more than one pharmacist or vet retailer exemptee may be employed at the site.

There can be multiple vet retailer exemptees working for a single vet retailer location, however each location must designate an exemptee-in-charge. If an exemptee-in-charge leaves the employment of the vet retailer, a new one must be designated within 30 days in writing on a form furnished by the board.

Licenses 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). Licenses are issued for one year, and must be renewed before expiration or else the vet retailer cannot operate until the license is renewed. Failure to renew the license within 60 days from the expiration date may result in the license being cancelled. If operations are to be resumed, a new application (with all documents) must be submitted and approved prior to business resumption.

IMPORTANT

Please follow these instructions completely. Failure to submit the necessary items will delay the processing of your application. Any forms that have been previously submitted with another application will not be pulled from the file. You must complete and submit all of the requested information. If the number of forms provided is not sufficient, please make photocopies. You will be notified of any deficiencies in your application. Please allow approximately 60 days from the time your application packet is complete before calling the Board of Pharmacy.

SUMMARY OF CHECKLIST

Section A	Requirements for all applicants
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 1. For profit 2. Non profit 3. Publicly traded corporation
Section E	Requirements for Indian tribe owned veterinary food-animal drug retailer
Section F	Requirements for non-Indian owned but operating on tribal lands
Section G	Change of location only

CHECKLIST FOR FILING A VETERINARY FOOD-ANIMAL DRUG RETAILER APPLICATION

Section A All Applicants

[ ] 1. The application fee of $400

[ ] 2. Completed application for Veterinary Food-Animal Drug Retailer license (17A-31)

[ ] 3. Ownership form

   a. Corporation (17A-33)
   OR
   b. Partnership or individual (17A-34)

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

[ ] 5. Copy of the lease agreement or grant deed.

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

[ ] 7. Report of Exemptee in Charge form (17A-3)
The exemptee must be licensed as a Veterinary Food-Animal Drug Retailer exemptee or a California licensed pharmacist.

[ ] 8. Individual Certification Affidavit (17A-37) for the exemptee-in-charge.

Section B Individual Owner who is not incorporated ONLY

In addition to items listed in section A, an individual owner must submit:

[ ] 1. Individual Certification Affidavit (17A-37)

[ ] 2. Individual Financial Affidavit (17A-26)

[ ] 3. 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 6.

Section C Partnership ONLY

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

[ ] 1. Each partner must submit:

- Individual Certification Affidavit (17A-37)
- Individual Financial Affidavit (form 17A-26)
- 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 6.

[ ] 2. Signed Partnership Agreement

Section D Corporation ONLY

The first line corporation over the vet retailer/wholesaler needs to complete a Corporation Ownership Information form (17A-33). Each remaining parent corporation, over the first line corporation, needs to complete a Parent Corporation or Limited Liability Company Ownership Information form (17A-33A).

For 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:

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

[ ] 1. Each owner, or top 5 corporate officers must submit:

- Individual Certification Affidavit (17A-37)
- Individual Financial Affidavit (form 17A-26)
- 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 6.

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

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:

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

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

[ ] 2. By-laws

Each corporate officer and board of director must submit:

[ ] 1. Individual Certification Affidavit (17A-37)

Publicly Traded Corporation

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

[ ] 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 Indian Owned ONLY

[ ] 1. Application (17A-31) and the non-refundable processing fee of $400.

[ ] 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 facility.

[ ] 4. Individual Certification Affidavit (17A-37) for the tribal council members and the administrator/CEO.

[ ] 5. 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 6.

Section F Non-Indian owned but operating on tribal lands ONLY

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 sole owner or partnership:

[ ] 1. All requirements listed in Section A.

[ ] 2. Documents describing the agreements with the Indian tribe to operate the veterinary food-animal drug retailer on tribal land.

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

Section G Change of Location ONLY (no ownership change) where the vet retailer is moving from one address to another

[ ] 1. The application fee of $60.

[ ] 2. A completed application for Veterinary Food-Animal Drug Retailer license (17A-31)

[ ] 3. Ownership

   a. Corporation (17A-33); **OR**
   b. Partnership or Individual (17A-34)

[ ] 4. Copy of the lease agreement or grant deed.

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

   a. Individual Certification Affidavit (17A-37)
   b. The board must have California fingerprint checks made of each of these individuals. If an individual has not previously submitted California fingerprints as part of a Board of Pharmacy application, they must be submitted. Please refer to fingerprint instructions on page 6.

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 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

For every owner, partner, corporate officer, major shareholder or director who resides out of state, he or she 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 fngerprint 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 requests 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-75a (08/03)

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Veterinary Food-Animal Drug Retailer Application

(Referred to as "Veterinary Retailer")

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

Name of Veterinary Retailer:	Veterinary Retailer telephone no: ( )

Address of Veterinary Retailer: Number and Street City State Zip Code

Indicate whether this application is for:

☐ Change of location of an existing veterinary retailer ☐ Change of ownership of an existing veterinary retailer ☐ New site operation

If this is a change of ownership or a change of location, indicate below the previous name, address and license number of veterinary retailer:

Name: Address: License Number:

California law requires that a veterinary retailer permit can only be issued to a board-licensed wholesaler premises. Please provide the following information regarding your wholesale premises at this location.

Name of Wholesaler:	Permit number:

Address of Wholesaler: Number and Street City State Zip Code

Indicate type of ownership of veterinary retailer:

☐ Individual ☐ Partnership ☐ Corporation ☐ Government owned

Type of Operation:

☐ Wholesaler of dangerous drugs and devices, including controlled substances

☐ Wholesaler of dangerous drugs and devices, without controlled substances

☐ Wholesaler of dialysis drugs and devices

☐ Reverse Distributor

☐ Customs Broker (Import/Export)

Continue on Reverse

For Office Use Only

☐ Articles of Incorp	☐ Financial aff	Approved _____	Cashier # _____
☐ Written policies	☐ Stock cert	Denied _____	Date _____
☐ Partnrshp agreement	☐ By-laws	Date _____	Amount _____
☐ Sellers' Cert	☐ Lease		

Complete the section below of who will be the exemptee-in-charge of veterinary retailer operations at this location.			
Exemptee-in-charge's name:		License number:	
Residence address:	City:	State:	Zip Code:

PLEASE READ CAREFULLY AND SIGN BELOW

This application must be approved by the California State Board of Pharmacy before a veterinary food-animal retailer 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, (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: (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; (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

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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. Makret 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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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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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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REPORT OF EXEMPTEE-IN-CHARGE

There must be one exemptee or pharmacist designated as the exemptee-in-charge for each wholesaler or veterinary food-animal drug retailer (vet retailer)* location. If the exemptee-in-charge leaves the employment of the wholesaler or vet retailer, a new exemptee-in-charge must be designated and reported to the board within 30 days.

The certificates and licenses of all exemptees or pharmacists working at the wholesaler or vet retailer must be current.

(Please print or type) **ALL SECTIONS MUST BE COMPLETED**

Name of wholesaler:		Telephone	Permit number (if known)	
Address : Number and Street		City	State	Zip Code
List below the name, license number and address of the exemptee-in-charge. **The designated person must hold a valid exemption certificate or pharmacist license.**				
Name			License Number	
Residence address Street		City	State	Zip Code

I 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.

_____
Type or print name of person designating exemptee-in-charge

_____ _____
Signature of person designating exemptee-in-charge Date

_____ _____
Signature of exemptee-in-charge Date

* exemptees for vet retailers must have specific training above that required for wholesale exemptees.

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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

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

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)

17A-2 (Rev. 10/00)

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

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)

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

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

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.

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: Veterinary Food-Animal Drug Retailer - 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: Veterinary Food-Animal Drug Retailer - 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: _____ 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.)

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: _____ 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: Veterinary Food-Animal Drug Retailer - Section 4201

(See instruction sheet for appropriate license types)

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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