California State Board of Pharmacy
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Phone: (916) 518-3100 Fax: (916) 574-8618
www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

PHARMACY CHANGE OF PERMIT APPLICATION

(17A-12)

Includes Resident and Nonresident:

Pharmacy, Remote Dispensing Site Pharmacy, Sterile Compounding Pharmacy,
Hospital Pharmacy/ Drug Room,
Licensed Correctional Pharmacy, Outsourcing Facility

A Change of Permit Application must be submitted to the Board within 30 days when one of the following in Section A occurs within a pharmacy license issued by the Board.

SECTION A **APPLICATION PROCESSING FEE:** Submit the appropriate application processing fee for EACH license affected by the change. If making changes that fall under 1 and 2, the fee is $130 for each license the changes affect. The application fee(s) is non-refundable.

Please mark all that apply and complete the corresponding sections. (All License Types)

1. **$45 Application Processing Fee**
   - ☐ Address Change (not a physical change of location): Complete Sections B, C, D, and J
   - ☐ Tradestyle Name Change: Complete Sections B, C, E, and J
   - ☐ Corporate Name Change: Complete Sections B, C, F, and J
2. **$130 Application Processing Fee**
   - ☐ Administrator: Complete Sections B, C, G, J, and K (Hospital Pharmacy/Drug Room)
   - ☐ Consulting Pharmacist: Complete Sections B, C, G, J, and K (Drug Room only)
   - ☐ Warden or Chief Executive Officer of a Licensed Correctional Pharmacy: Complete Sections B, C, G, J, and K (Correctional Pharmacy only)
   - ☐ Officer(s)/Director(s)/Manager(s)/Member(s)/Partner(s)/Owner(s): Complete Sections B, C, H, J, and K (all licenses with the exception of sterile compounding)
   - ☐ Transfer an Assignment of Beneficial Interest: Complete Sections B, C, I, J, and K (all licenses with the exception of sterile compounding)

SECTION B **LICENSEE INFORMATION** (Please Type or Print) *Complete a separate Change of Permit Application (17A-12) for EACH license affected by the change.*

1) _____ _____
Name of Licensee as it appears on the current License – may include DBA License Type and Number

2) _____
Address of Licensee: Number and Street City State Zip Code

3) _____ _____
Email Address of Licensee Telephone Number

Board Use ONLY - Cashier #_____ Date _____ Amount _____
Date Processed: _____By _____ Date Approved:_____ By _____

A check box is provided next to each section to assist in providing the appropriate supporting documentation with the application. Failure to submit the supporting documentation may result in a delay in updating the license record which may impact your license renewal.

SECTION C **CONTACT PERSON AND AUTHORIZED SIGNER:** The Board will communicate deficiencies and status of application to the contact person via email. The Board will ONLY discuss the status of this application with the person identified as the contact person and any person who is listed on the license.

1) _____ _____ _____
Name of Contact Person Telephone Number Email Address

2) _____
Address: Number and Street City State Zip Code

SECTION D **ADDRESS CHANGE (not a physical change of location):** This ONLY includes a change of street name or number made by the United States Postal Service (USPS), government entity, suite number, etc. *This does NOT include a physical change of location. A physical change of location requires a new license application.*

1) Submit one of the required supporting documentations:
   - ☐ A copy of the notice received from the USPS or Government entity reporting the change.
   - ☐ A copy of the lease agreement showing the new address.
   - ☐ Board minutes ratifying the address change.
   - ☐ Clear floor plans with documentation.

2) **Effective Date of Change** (*mm/dd/yyyy*) _____

3) _____
New Address: Number and Street City State Zip Code

SECTION E **CHANGE OF TRADESTYLE NAME:** This does NOT include a change of ownership. *A change of ownership requires a new license application.*

1) Submit one of the required supporting documentations:
   - ☐ Fictitious business name statement filed with the county. (In state facilities only)
   - ☐ Copy of home state license reflecting the name change. (Nonresident facilities only)
   - ☐ Copy of the board minutes ratifying the name change.
   - ☐ Other official document supporting the name change.

2) **Effective Date of Change** (*mm/dd/yyyy*) _____

3) _____
New name of Licensee to appear on the License: may include DBA (Name cannot exceed 65 characters)

SECTION F **CHANGE OF CORPORATE NAME:** This does NOT include a change of ownership. *A change of ownership requires a new license application.* Reporting a corporate name change is required for any of the parent entities within the ownership tier of the licensee.

1) Submit one of the required supporting documentations:
   - ☐ Copy of the amended Articles of Incorporation/Organization or Certificate of Limited Partnership listing the new name.
   - ☐ Copy of the board minutes ratifying the name change

2) **Effective Date of Change** (*mm/dd/yyyy*) _____ **Check one:** ☐ Licensee Entity ☐ Parent Entity

3) _____
   Current Corporate Name

4) _____
   New Corporate Name

SECTION G **NOTIFICATION TO ADD AND REMOVE AN ADMINISTRATOR, CONSULTING PHARMACIST, WARDEN OR CHIEF EXECUTIVE OFFICER FOR CORRECTIONAL FACILITY ONLY.**

1) Submit the required supporting documentation for each individual added or removed from the license record.
   - ☐ Certificate of Personnel (17A-11): Submit a completed form for the new individual(s) being added. (*The 17A-11 form is not required to be completed for consulting pharmacists.)*
   - ☐ Fingerprints: Any new person being added to the license. Please reference Section K of the application instructions.

2) **Please identify the changes:** The type of change must be checked**.** *Use additional sheets, if necessary.*

Effective Date of Change (*Use exact date*)_____ **Change Type:** ☐Add ☐Delete
Title Type: ☐Administrator ☐Consulting Pharmacist ☐Warden ☐Chief Executive Officer

_____ _____
Full Legal Name Professional License Type and Number

_____
Resident Address Number and Street City State Zip Code

Effective Date of Change (*Use exact date*)_____ **Change Type:** ☐Add ☐Delete
Title Type: ☐Administrator ☐Consulting Pharmacist ☐Warden ☐Chief Executive Officer

_____ _____
Full Legal Name Professional License Type and Number

_____
Resident Address Number and Street City State Zip Code

SECTION H **NOTIFICATION TO ADD, REMOVE AND/OR TITLE CHANGE:** OFFICER(S), DIRECTOR(S), PARTNER(S), MEMBER(S), MANAGER(S), OWNER(S).

1) Submit the required supporting documentation for each individual being added or removed from the license record.
   - ☐ Certificate of Personnel (17A-11): Submit a completed form for the new individual(s) being added.
   - ☐ Individual Personal Affidavit (17A-27): Submit a completed form for the new individual(s) being added.
   - ☐ Documentation verifying the added or removed individual(s). Documentation may include the following:
     - ☐ Statement of Information. Copy of the filing with the Secretary of State reflecting the officer change and bearing the Secretary of State stamp.
     - ☐ A copy of the board minutes reflecting the change.
     - ☐ Letter of resignation or memo reflecting the change. The documentation must also reflect the termination date.
     - ☐ Letter of appointment or memo reflecting the change. The documentation must also reflect the effective date of the appointment of the individual into the position.
   - ☐ Fingerprints: Any new person being added to the license. Please reference Section K of the application instructions.

2) Please identify **ALL**: Owner(s), Corporation-the officer(s) and Director(s); Partnership-the partner(s); Limited Liability Company-the member(s), manager(s) and/or officer(s). The type of change must be checked**.** If no change, check "No Change". *Use additional sheets, if necessary.*

Effective Date of Change (*Use exact date*)_____ ☐Add ☐Delete ☐Change Title ☐No Change

_____ _____
Full Legal Name List all Titles

_____
Resident Address Number and Street City State Zip Code

Effective Date of Change (*Use exact date*)_____ ☐Add ☐Delete ☐Change Title ☐No Change

_____ _____
Full Legal Name List all Titles

_____
Resident Address Number and Street City State Zip Code

Effective Date of Change (*Use exact date*)_____ ☐Add ☐Delete ☐Change Title ☐No Change

_____ _____
Full Legal Name List all Titles

_____
Resident Address Number and Street City State Zip Code

SECTION I **TRANSFER AN ASSIGNEMENT OF BENEFICIAL INTEREST (ownership, stock, etc.)** Submit the required documentation below when the change to beneficial interest is within 10% to 49%, which does **NOT** result in the transferee holding 50% or more beneficial interest in the license in a single transaction or in a series of transactions, to any person or entity.

NOTE: Change of Ownership: *A transfer of beneficial interest in the facility licensed by the board, in a single transaction or in a series of transactions, to any person or entity, which transfer* ***results in*** *the transferee's holding* ***50% or more of the beneficial interest*** *in the licensed facility shall complete the appropriate licensing application and submit all required documents as instructed in a change of ownership application.* ***A Change of Ownership requires a new license application.*** *All approved change of ownership applications will result in a new license number being issued.*

1) Submit the required supporting documentation:
   - ☐ Certification of Personnel (17A-11): Submit a completed form for each NEW partner, member, and/or owner with original signature.
   - ☐ Individual Personal Affidavit (17A-27): Submit a completed form for each NEW partner, member, and/or owner with original signature.
   - ☐ Individual Financial Affidavit (17A-26): Submit a completed form for each NEW partner, member, and/or owner with original signature.
   - ☐ Organizational Chart: Submit an organizational chart defining the ownership structure before and after the change, including percentages owned by all parties.
   - ☐ Purchase Agreement/Documentation of Transfer: If the beneficial interest was acquired through a purchase agreement, submit a copy of the purchase agreement and documentation of the completed transaction.
   - ☐ Supporting Ownership Documentation:
     - ☐ Ownership Information (17A-33)
     - ☐ Articles of Organization/Incorporation/Certificate of Limited Partnership
     - ☐ Statement of Information
     - ☐ Corporate Bylaws/Limited Liability Agreement/Partnership Agreement
     - ☐ Stock Certificates: Submit copies of currently issued stock certificates supporting the change. Please note: you may be asked to provide additional share holder information.
     - ☐ Stock Ledger: Submit documentation supporting the change of all current stock owners and shares owned by each person.
   - ☐ Indian Owned, if applicable: A copy of the constitution and bylaws establishing the tribal council that will be the governing entity of the licensed facility.
   - ☐ Fingerprints: Any new person being added to the license. If a person is currently associated with an active license and has fingerprints on file with the California State Board of Pharmacy, new fingerprints may not be required. Please reference Section K of the application instructions.

2) List the partner(s), member(s), or owner(s) with beneficial interest in the license along with the percentage of their current percentage of interest and/or new percentage of interest below. *Use additional sheets, if necessary.*

Effective Date of Change (*Use exact date*)_____ ____% of Interest Before ____% of Interest After

_____ _____

Full Legal Name Position Title(s)

_____

Resident Address Street City State Zip Code

Effective Date of Change (*Use exact date*)_____ ____% of Interest Before ____% of Interest After

_____ _____
Full Legal Name Position Title(s)

_____
Resident Address Street City State Zip Code

Effective Date of Change (*Use exact date*)_____ ____% of Interest Before ____% of Interest After

_____ _____
Full Legal Name Position Title(s)

_____
Resident Address Street City State Zip Code

SECTION J Required Signature(s)

Any material misrepresentation provided to the Board is grounds for refusal or subsequent revocation of license, and a violation of the Penal Code of the State of California.

Under penalty of perjury, under the laws of the State of California, the person whose signature appears below, certifies and says:

1. Is the **owner, officer, director, manager, partner, member, administrator, director, or warden** of this license and is duly authorized to report these notifications on its behalf and is at least 18 years of age.
2. There have been no changes in officer(s), director(s), manager(s), partner(s), member(s), or owner(s) that have not been reported to the Board of Pharmacy and that each such officer, director, manager, partner, member, or owner listed is the real party in interest with respect to his/her position and is not acting directly or indirectly as an agent, employee or representative of any other person not reported to the board
3. Has read the foregoing application and knows the contents thereof and that each and all statements therein made are true.
4. Has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license(s) for which this application is made; and
5. All supplemental statements are true and accurate.

Provide original signature. Scanned, stamped or electronic signature may not be accepted.

_____ _____ _____
Original Signature Printed Name Date

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. Provide original signature. Scanned, stamped or electronic signature may not be accepted.

_____ _____ _____
Original Signature of New Administrator, Consulting Pharmacist, or Warden/Chief Executive Officer of Correctional Pharmacy Printed Name Date

SECTION K FINGERPRINTS (Not required if the license is government owned by the state, city or county.)

Each person who is required to complete a Certification of Personnel is required to complete the Live Scan or submit the Board approved fingerprint cards for a criminal background check with the Department of Justice (DOJ) and Federal Bureau of Investigation (FBI). If a person is currently associated with an active facility license and has electronic fingerprints on file with the California State Board of Pharmacy, new fingerprints may not be required.

- **Officer:** Any New officer(s) listed on the application.
- **Director:** Any New director(s) listed on the application.
- **Partner:** Any New partner(s) listed on application.
- **Limited Liability Company:** Any New member(s) listed on application.
- **Manager:** Any New manager(s) listed on the application.
- **Owner:** Any New owner(s) listed on the application.
- **Administrator:** New administrator listed on the application.
- **Consulting Pharmacist:** Only required if the Board does not have an electronic fingerprint record on file with your pharmacist license. The Board will notify you upon submission of the change of consulting pharmacist if fingerprints are required.
- **Warden/Chief Executive Officer of a Correctional Pharmacy:** Government entities are exempt from fingerprinting.

Fingerprint Instructions: Complete and attach **ONE** of the following (submit either 1 or 2)

- 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).

1. 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 his/her 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 – Sect 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 or ITIN number. If left blank you may have to reprint. If you have an ITIN, enter this number in the SSN field.
- **Level of Service:** Must include both DOJ and FBI.

2. 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.

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CERTIFICATION OF PERSONNEL

This form is completed by each natural person listed on the application/license that has beneficial interest and/or management and control. A California licensed pharmacist only acting as the pharmacist-in-charge/consulting pharmacist does not need to complete this form unless listed as a natural person on the application. Failure to complete the form and provide the required information may result in the application being considered incomplete. Attach additional sheets of paper, if necessary.

Personal Information - Please Type or Print

_____ _____ _____
Full Legal Name - Last Name | First Name | Middle Name

_____
Previous Names (AKA, Maiden Name, Alias, etc.)

_____
Residence Address - Street | City | State | Zip Code

_____ _____ _____
Telephone Numbers - Home | Cell | Work

_____ _____ _____
Email Address | **US Social Security Number or ITIN | Date of Birth (Month/Day/Year)

Applicant Business Information

_____ _____
Name of Applicant Business | Business Telephone Number

_____
Applicant Business Address - Street | City | State | Zip Code

Position with the Applicant Business is: (Check all that apply)

____ Owner ____ Partner ____ Officer ____ Stockholder ____ Member ____ Trustee
____ Government Representative ____ Professional Director ____ Administrator
____ Other, please specify the position _____

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS (Attach additional sheets of paper if necessary)

1. Are you currently licensed as a physician, podiatrist, dentist, optometrist, or veterinarian in any state, territory, foreign country, or other jurisdiction, please provide the following information?
Yes ____ **No**____ If Yes, provide the following.

State	License Type and Number	Active or Inactive	Issued Date	Expiration Date
State	License Type and Number	Active or Inactive	Issued Date	Expiration Date

2. Is your spouse, child, parent, or other relative or any person with whom you share a financial interest is licensed in this state or any other state as a physician, podiatrist, dentist, or veterinarian, please list his or her name, relationship to you, the license type and number, and state? (Use additional sheets if necessary.)
Yes ____ **No**____ If Yes, provide the following.

Name	Relationship	License Type and Number	State
Name	Relationship	License Type and Number	State

3. Ownership Information

A. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator, or medical director on a license to conduct a pharmacy, wholesaler, third-party logistics provider, or any other entity licensed in any state, territory, foreign country, or other jurisdiction?
Yes ____ **No**____ If Yes, attach a statement of explanation including company name, type of license, license number, and identify the state, territory, foreign country, or other jurisdiction where licensed.

4. Disciplinary History

The following questions pertain to a license sought or held in any state, territory, foreign country, or other jurisdiction. For any affirmative answer, attach a statement of explanation including type of license, license number, type of action, date of action, and identify the state, territory, foreign country, or other jurisdiction.

A. Have you ever had an application for pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration denied?
Yes ____ **No**____

B. Have you ever had a pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration suspended, revoked, placed on probation, or had other disciplinary action taken against it?
Yes ____ **No**____

C. Have you ever had a pharmacy, wholesaler, third-party logistics provider, and/or any other entity license denied, suspended, revoked, placed on probation, or had other disciplinary action taken against a license you hold?
Yes ____ **No**____

5. Practice Impairment or Limitation

The board makes an individualized assessment of the nature, the severity, and the duration of the risks associated with any identified condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether the applicant is not qualified for licensure. If the board is unable to make a determination based on the information provided, the board may require an applicant to be examined by one or more physicians or psychologists, at the board's cost, to obtain an independent evaluation of whether the applicant is able to safely practice despite the mental illness or physical illness affecting competency. A copy of any independent evaluation would be provided to the applicant.

A. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice safely?
Yes ____ **No**____ If Yes, attach a statement of explanation.

B. Have you ever been diagnosed with a physical condition that may impair your ability to practice safely?
Yes ____ **No**____ If Yes, attach a statement of explanation.

C. Do you have any other condition that may in any way impair or limit your ability to practice safely?
Yes ____ **No**____ If Yes, attach a statement of explanation.

D. Have you ever participated in, been enrolled in, or required to enter into any drug, alcohol, or substance abuse recovery program or impaired practitioner program?
Yes ____ **No**____ If Yes, attach a statement of explanation.

E. If you answered "Yes" to questions listed under 5 (A through D) above, have you ever received treatment or participated in any program that improves your ability to practice safely?
Yes ____ **No**____ **N/A**____ If Yes, attach a statement of explanation.

APPLICANT AFFIDAVIT - Please read carefully and sign below.

Please provide a written explanation for all affirmative answers. Failure to provide any of the requested information may result in the application being deemed incomplete. Falsification of the information on this application may constitute grounds for denial or revocation of the license.

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 that is prohibited by law.
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.

(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 that 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 by prescription or to persons who are licensed to handle, sell and possess such drugs.

This information will be used to determine qualifications for licensure under California pharmacy law. The officer responsible for information maintenance is the Executive Officer at the California State Board of Pharmacy. This information may be transferred to another governmental agency, such as a law enforcement agency, if necessary, 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.

****Disclosure of your U.S. Social Security number or individual taxpayer identification number (ITIN) is mandatory.** Business and Professions Code section 30, Family Code section 17520, and Public Law 94-455 (42 USC § 405(c)(2)(C)) authorize collection of your Social Security number or individual taxpayer identification number. Your Social Security number or individual taxpayer identification number will be used exclusively for tax enforcement purposes; for purposes of compliance with any judgment or order for child or family support in accordance with section 17520 of the Family Law Code; or for verification of license or examination status by a licensing or examination entity that utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your Social Security number or individual taxpayer identification number, your application will not be processed and you may be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

NOTICE: The State Board of Equalization and the Franchise Tax Board may share 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 your 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, including all supplementary statements; and that I personally completed this personal background affidavit. I understand that my application may be denied, or any license disciplined for fraud or misrepresentation.

Provide Original Signature.

_____ _____

Signature of Applicant (please sign and date within 60 days of filing the application) Date

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INDIVIDUAL PERSONAL AFFIDAVIT

TAPE A COLOR PASSPORT STYLE 2"X2" PHOTO TAKEN WITHIN 60 DAYS OF THE FILING OF THIS APPLICATION

NO POLAROID

OR
SCANNED IMAGES

1. Applicant Information - Please Type or Print

_____
Name of Applicant Business

_____
Address of Applicant Business Street

_____
City State Zip Code

2. Individual Information

_____ _____ _____ _____
Full Legal Name - Last Name Suffix First Name Middle Name

_____
Previous Names (AKA, Maiden Name, Alias, etc.)

_____
Residence Address - Street City State Zip Code

_____ _____ _____
Telephone Numbers - Home Cell Work

_____ _____
Driver's License Number State Email Address

_____ _____
Date of Birth (Month/Day/Year) **US Social Security Number or ITIN

3. My position with the applicant business is (check all that apply):
☐ Sole Owner ☐ Director ☐ Stockholder _____% owned ☐ Partner ☐ Officer
☐ Member and/or Manager (LLC only) ☐ Other, please specify_____

4. Spouse Information

_____ _____ _____ _____
Full Legal Name - Last Name Suffix First Name Middle Name

_____
Previous Names (AKA, Maiden Name, Alias, etc.)

_____ _____
Date of Birth (Month/Day/Year) **US Social Security Number or ITIN

Will your spouse work in any capacity under the license? ☐ Yes ☐ No
If yes, what capacity? _____ If Licensed, list license number _____

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

____ Yes ____ No

If yes, list all current and past direct or indirect beneficial interests below. Attach additional sheets if necessary.

Name of Premises	License Number	State Issued
Address: Street	City	State Zip Code
Name of Premises	License Number	State Issued
Address: Street	City	State Zip Code
Name of Premises	License Number	State Issued
Address: Street	City	State Zip Code

6. Disciplinary History

The following questions pertain to a license sought or held in any state, territory, foreign country, or other jurisdiction. For any affirmative answer, attach a statement of explanation including type of license, license number, type of action, date of action, and identify the state, territory, foreign country, or other jurisdiction.

A. Have you ever had an application for pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, physician, nurse practitioner, physician assistant, podiatrist, optometrist, veterinarian, dentist, attorney, contractor, and/or any other professional or vocational license or registration denied?
Yes ____ No____

B. Have you ever had a pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, physician, nurse practitioner, physician assistant, podiatrist, optometrist, veterinarian, dentist, attorney, contractor, and/or any other professional or vocational license or registration suspended, revoked, placed on probation, or had other disciplinary action taken against it?
Yes ____ No____

C. Have you ever had a pharmacy, wholesaler, third-party logistics provider, and/or any other entity license denied, suspended, revoked, placed on probation, or had other disciplinary action taken against a license you hold?
Yes ____ No____

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, attach a statement of explanation that describes the event, regulatory agency involved and date for each incident.

7. Current and Past Employment for at least the last five years.

From mm/yy	To mm/yy	Type of Work	Firm Name and City

Please Read Carefully

**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 judgment 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 Signature

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's Signature	Title	Date

Notary Public

Attest Notary Public	Place	Date

California State Board of Pharmacy
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Phone: (916) 518-3100 Fax: (916) 574-8618
www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

INDIVIDUAL FINANCIAL AFFIDAVIT

Please print or type.

Personal Information – Do not leave blanks, if not applicable, indicate NA.

Full Legal Name - Last Name _____ First Name _____ Middle Name _____

Residence Address Number and Street _____ City _____ State _____ Zip Code _____

Telephone Numbers - Home _____ Cell _____ Work _____

Applicant Business Information

Name of Applicant Business _____ Business Telephone Number _____

Applicant Business Address - Street _____ City _____ State _____ Zip Code _____

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 the loan agreement)
___ I am not making a contribution in any form.

SOURCE OF FUNDS USED TO FINANCE BUSINESS (Please use additional sheets if necessary)

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

Financial Institution	City and State	Amount	Account Number	Source of Savings
Financial Institution	City and State	Amount	Account Number	Source of Savings

CHECKING

Financial Institution	City and State	Amount	Account Number	Source of Checking
Financial Institution	City and State	Amount	Account Number	Source of Checking

LOANS & CREDIT APPLICATIONS FOR THIS BUSINESS

Date	Amount	Term	Item Secured	Security	Lender
Date	Amount	Term	Item Secured	Security	Lender

SALE OF PROPERTY TO FINANCE THIS BUSINESS

Type	Date	Buyer	Net Proceeds	Other Source

Location of Property: _____

Type	Date Sold	Buyer	Net Proceeds	Other Source

Location of Property: _____

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 this application, from this date and pursuant to section 4207 of the Business and Professions Code, I hereby authorize the California State 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.

_____ _____

Signature Title Date

Notary Public

_____ _____

Attest Notary Public Place Date

California State Board of Pharmacy
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Phone: (916) 518-3100 Fax: (916) 574-8618
www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, 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, at the address listed above. 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.

1. Applicant Information

_____

Name of Applicant Business

_____

Address of Applicant Business Street City State Zip Code

2. 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**.

Amount $_____

Source _____

_____

_____

3. 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.

Amount $_____

_____ _____

Name of source Telephone Number

_____

Address Street City State Zip Code

Source _____

_____

4. If the pharmacy is franchised, list the name of franchisor. Please include the franchise agreement.

_____

5. Who will be the **primary** wholesaler for dangerous drugs and/or dangerous devices? Please attach an **approved** wholesale credit application or wholesale agreement.

_____ _____

Name of Primary Wholesaler Telephone Number

_____

Address Street City State Zip Code

6. Who will be the **secondary** wholesaler for dangerous drugs and/or dangerous devices? Please attach an **approved** wholesale credit or wholesale credit application or wholesale agreement.

_____ _____

Name of Secondary Wholesaler Telephone Number

_____

Address Street City State Zip Code

7. Business Bank Information – Please submit a copy of most recent bank statement for each account listed.

_____ _____ _____ _____

Bank Name Telephone Number Account Number Balance of Account

_____

Address Street City State Zip Code

_____ _____ _____ _____

Bank Name Telephone Number Account Number Balance of Account

_____

Address Street City State Zip Code

List all individuals authorized to sign on business bank account.

_____ _____ _____

Signature Name (please print) Title

_____ _____ _____

Signature Name (please print) Title

_____ _____ _____

Signature Name (please print) Title

_____ _____ _____

Signature Name (please print) Title

8. Bookkeeper/Accountant Information

_____ _____

Name of Bookkeeper/Accountant for Applicant Premises Telephone Number

_____

Address Street City State Zip Code

Estimated Annual Gross Sales $_____ Estimated Annual Purchases $_____

APPLICANT(S) AUTHORIZATION FOR DISCLOSURE OF FINANCIAL RECORDS

From this date until the issuance of this license, 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 hereby authorize the California State 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 also authorize the California State 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 agree to furnish current financial information on the annual renewal if requested by the California State Board of Pharmacy.

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.

1. Is the owner, a partner, a member/manager, an officer, a director, a trustee, or a tribal council member (Native American owned) of the applicant pharmacy named in the foregoing application, is duly authorized to make this application on its behalf and is at least 18 years of age.
2. Has read the foregoing application and knows the contents thereof and that each and all statements therein made are true.
3. Understands that falsification of any information in this application may constitute grounds for denial or subsequent revocation of the license.
4. All supplemental statements are true and accurate.

_____ _____ _____

Signature Name (please print) Title Date

Notary Public

_____ _____ _____

Attest Notary Public Place Date

INSTRUCTIONS FOR COMPLETING A
"REQUEST FOR LIVE SCAN SERVICE" FORM

California Live Scan
The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly.

NOTE TO APPLICANT/LICENSEE and LIVE SCAN OPERATOR: The name, date of birth and US Social
Security Number (SSN) must be entered in at the time of the Live Scan transmission for the results to be accepted by the California State Board of Pharmacy. If the name, date of birth or SSN is not entered at the time of Live Scan transmission, the individual may have to have a new Live Scan transmission completed.

Type of License/Certification or Permit or Working Title: The Live Scan operator must enter in the Type of License that is specified on the Request for Live Scan Service form.

Applicant Information:

- **Name:** Enter your last name, first name and middle name that matches your government issued driver's license or state identification. Do not use initials or name abbreviations. Your legal name must be on file with the board. If your name has changed you are required to notify the board within 30 days of the change.
- **Other Name (AKA):** Enter all other names you have used, including your maiden name.
- **Date of Birth:** (month/day/year).
- **SEX:** Mark the appropriate gender box (male or female)
- **Driver's License Number:** Driver's License Number.
- **Height:** Your height in feet and inches.
- **Weight:** Your weight in pounds.
- **Eye Color:** Color of your eyes
- **Hair Color:** Color of your hair
- **Place of Birth:** Enter your place of birth
- **Social Security Number:** Must be included and be correct, unless you have an ITIN. If you have an ITIN, then this field should be left blank.
- **Misc. Number:** Other identification number
- **Home Address:** Your residence address

Level of Service: This has already been preselected for you. You are required to have both DOJ and FBI level of service complete. Please ensure at the time of Live Scan transmission that the Live Scan operator selects both the DOJ and FBI levels of service in their computer system. If FBI is not selected at the time of original transmission, you will be required to have your Live Scan redone at another time and repay for the DOJ and FBI levels of services again. The board has been notified by the DOJ that effective 9/1/07, if the FBI level of service is not requested at the time of original transmission both DOJ and FBI levels of service will have to be redone. Any issue of cost for resubmission should be handled at the Live Scan Site level.

Employer: This information is not required.

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 https://oag.ca.gov/fingerprints/locations 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 $17, 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 for the DOJ/FBI to conduct background checks for criminal convictions.

STATE OF CALIFORNIA
BCII 8016
(orig. 4/01; rev. 6/09)

DEPARTMENT OF JUSTICE

REQUEST FOR LIVE SCAN SERVICE

Print Form | Reset Form

Applicant Submission

A0071
ORI (Code assigned by DOJ)

License/Cert/Permit
Authorized Applicant Type

Pharmacy - Section 4201
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Board of Pharmacy
Agency Authorized to Receive Criminal Record Information

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

2720 Gateway Oaks Drive, Suite 100
Street Address or P.O. Box

Licensing
Contact Name (mandatory for all school submissions)

Sacramento
City

CA
State

95833
ZIP Code

9165183100
Contact Telephone Number

Applicant Information:

Last Name

First Name | Middle Initial | Suffix

Other Name (AKA or Alias) Last

First | Suffix

Date of Birth

Sex ☐ Male ☐ Female

Driver's License Number

Height | Weight | Eye Color | Hair Color

Billing Number
(Agency Billing Number)

Place of Birth (State or Country)

Social Security Number

Misc. Number BIL - Applicant Must Pay Fees
(Other Identification Number)

Home Address Street Address or P.O. Box

City | State | ZIP Code

Your Number: N/A
OCA Number (Agency Identifying Number)

Level of Service: ☒ DOJ ☒ FBI

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

N/A
Employer Name

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

N/A
Street Address or P.O. Box

N/A
City

State

ZIP Code

N/A
Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed

ORIGINAL - Live Scan Operator | SECOND COPY - Applicant | THIRD COPY (if needed) - Requesting Agency