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

APPLICATION FOR CHANGE OF RESPONSIBLE MANAGER (RMG)

The owner of a third-party logistics provider or nonresident third-party logistics provider and the RMG are required by California law to notify the California State Board of Pharmacy in writing within 30 days after the termination or change of the RMG. Failure to make this notification to the board may result in a citation and fine or other disciplinary action.

INSTRUCTIONS: Submit a Change of RMG form and $130 Application Fee. Please make checks payable to the Board of Pharmacy (California government owned facilities are fee exempt). Important: LIST the license number for the facility and the RMG.

Licensed Facility Location - Please Type or Print

_____ _____
Name of License Facility Facility License Number

_____
Address of Facility – Street City State Zip Code

_____
Name of Person Authorized to Clarify Information provided on this form

_____ _____
Telephone Number Email Address

New RMG

_____ _____
Name of New RMG License Number

_____
Residence Address – Street City State Zip Code

_____
Effective Start Date of New RMG

RMG being REPLACED

_____ _____
Name of the RMG License Number

_____
Residence Address – Street City State Zip Code

_____
End Date as RMG

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. (Please provide original signatures.)

_____ _____ _____ _____
Signature of Corporate Officer, Partner, Owner or Member | Print Name | Title | Date

_____ _____ _____
Signature of New RMG Date | Signature of replaced RMG (If available) | Date

17A-E9 (4/2019)
Board Use ONLY - Cashier #_____ Date _____ Amount _____

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PERSONAL BACKGROUND AFFIDAVIT

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, designated representative, designated representative-3PL, or a designated representative-reverser distributor 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.

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