



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



HYPODERMIC NEEDLE & SYRINGE LICENSE APPLICATION INSTRUCTIONS

No person shall furnish hypodermic needles or syringes, by sale or otherwise, without a license issued by the board.

IMPORTANT: Please follow these instructions completely. Failure to submit the necessary items will delay the processing of your application. If the number of forms included in this application is insufficient, please make copies. Please allow approximately 45 days from the date your application is submitted before checking on the status. The contact person designated on the application will be advised if additional information is necessary.

A checklist is provided with these instructions. The board encourages the submission of all required documentation with the application as well as the use of the checklist to assist with the application process. The board may request additional documentation to confirm or substantiate information in the application. When submitting documents to the board, please make a copy for your records.

SUMMARY OF CHECKLIST

Section A Hypodermic Needle and Syringe Application and Processing Fee (All Applicants)

Section B Change of Ownership / Location

Section C Hypodermic Needle and Syringe Ownership Documents (All Applicants) - Please refer to the respective ownership section (C1-C6) in the application instructions to identify the appropriate ownership documents to submit with the application.

C1 Individually Owned

C2 Partnership

C3 Corporation (Not Publicly Traded)

C4 Publicly Traded Corporation

C5 Limited Liability Company

C6 Trust

Section D Fingerprint Requirements (All Applicants)

CHECKLIST FOR FILING A HYPODERMIC NEEDLE AND SYRINGE APPLICATION

Section A Hypodermic Needle and Syringe Application and Processing Fee (All Applicants)

All applicants are required to complete and submit the following:

- 1. Hypodermic Needle and Syringe Application (17A-15):** Complete the entire application and submit with original signatures.
 - **Do Not Leave Blanks:** If an item or question is not applicable, indicate N/A.
 - **Doing Business As (DBA):** If using a DBA, submit a completed Fictitious Business Name Statement that has been certified by the Office of the County Clerk in the county in which it was filed.
- 2. Application Processing Fee postmarked through March 31, 2020 is \$170. Effective April 1, 2020, the application fee postmarked On or After April 1, 2020 is \$240.** Include a check or money order made payable to the California State Board of Pharmacy. This fee is nonrefundable
- 3. Organizational Chart:** Provide a business ownership organizational chart that clearly documents the applicant business' ownership structure with the application. Include percentages owned by all parties and list the top five executive officers under the appropriate entity. If submitting a change of ownership application, include both the pre and post-closing organizational structures.

Section B Change of Ownership / Location

A hypodermic needle and syringe license is nontransferable. A license is issued to the owner(s) and for the location of the facility. All approved change of ownership and change of location applications will result in a new license number being issued. Operating the facility prior to a new license being issued is unlicensed activity and may result in denial or disciplinary action by the board.

- 1. Change of Ownership Documentation:** In addition to the application requirements in Sections A, C, D, and E submit the following for a change of ownership application.
 - Seller's Certification (17A-8)
 - Copy of the signed proposed purchase agreement.
 - A copy of the final sale/closing documents will need to be submitted by the applicant applying for the Hypodermic Needle and Syringe license prior to the issuance of the license.
 - Organizational Chart: Provide a business ownership organizational chart that clearly documents the applicant's business ownership structure with the application. Include both the pre- and post-closing business ownership structure that includes each level of ownership with corresponding percentage of ownership.

Section C Hypodermic Needle and Syringe Ownership Documents (All Applicants)

California Business and Professions Code section 4035 specifies "person" includes a firm, association, partnership, corporation, limited liability company, state governmental agency, trust, or political subdivision.

California Business and Professions Code section 4201(a) requires that "... the application shall state the information as to each person beneficially interested therein or any person with management or control over the license."

The application shall provide information to identify the ownership of the applicant business. The board may require additional documentation to confirm or substantiate the reported ownership structure.

Provide ownership documents listed under the appropriate ownership type in Section C for the applicant business.

- C1 Individual Owner (Sole Proprietor)** In addition to items listed in Sections A and D submit the following:
- The individual owner needs to complete and submit a Personal Background Affidavit (17A-37)
- C2 Partnership** In addition to items listed in Sections A and D submit the following:
1. Personal Background Affidavit (17A-37):
 - Partner(s)
 - Executive officer(s)
(If the applicant business does not hold executive officers, list the executive officers for the parent entity or the entity above the parent which holds the executive officers. The executive officer(s) must be identified by name and officer title on the organizational chart.)
 2. Business Background Affidavit (17A-18):
 - The applicant business
 - The parent entity(ies)
 3. Partnership Agreement: Provide a copy of the current executed partnership agreement for the applicant business.
- C3 Corporation (Not Publicly Traded)** In addition to items listed in Sections A and D submit the following:
1. Personal Background Affidavit (17A-37):
 - Executive officer(s)
(If the applicant business does not hold executive officers, list the executive officers for the parent entity or the entity above the parent which holds the executive officers. The executive officer(s) must be identified by name and officer title on the organizational chart.)
 2. Business Background Affidavit (17A-18):
 - The applicant business
 - The parent entity(ies)
 3. Articles of Incorporation: Provide a copy of the Articles of Incorporation filed with the Secretary of State for the applicant business bearing the Secretary of State's stamp (proof of filing).
 4. Statement of Information (a or b):
 - a. Provide a copy of the current filing with the Secretary of State bearing the Secretary of State's stamp that discloses the current officers on file for the entity. For more information, go to http://www.sos.ca.gov/business/corp/pdf/so/corp_so350.pdf.
 - OR**
 - b. Statement by Foreign Corporation **endorsed** by the California Secretary of State. *This is only required if the named corporation on the application is incorporated outside of California.*

5. Stock Certificates and Stock Ledger: Provide a copy of stock certificate(s) front and back along with a copy of the stock ledger, if stocks are issued. If stocks are not issued, please provide a statement that states as such signed by an officer listed on the application.
6. Bylaws: Provide a copy of the bylaws or internal operating rules for the applicant business.

C4 Publicly Traded Corporation In addition to items listed in Sections A and D submit the following:

1. Personal Background Affidavit (17A-37):
 - Executive officer(s)
2. Business Background Affidavit (17A-18):
 - The applicant business
3. Corporation's 10K Filing: Provide a copy of the document filed with the Securities Exchange Commission.

C5 Limited Liability Company In addition to items listed in Sections A and D submit the following:

1. Personal Background Affidavit (17A-37):
 - Members
 - Executive officer(s)
(If the applicant business does not hold executive officers, list the executive officers for the parent entity or the entity above the parent which holds the executive officers. The executive officer(s) must be identified by name and officer title on the organizational chart.)
2. Business Background Affidavit (17A-18):
 - The applicant business
 - The parent/member entity(ies)
3. Articles of Organization: Provide a copy of the Articles of Organization filed with the Secretary of State for the applicant business.
4. Statement of Information (a or b):
 - a. Provide a copy of the current filing with the Secretary of State bearing the Secretary of State's stamp that discloses the current officers on file for the entity. For more information, go to http://www.sos.ca.gov/business/corp/pdf/so/corp_so350.pdf
 - OR**
 - b. Statement by Foreign Corporation **endorsed** by the California Secretary of State. *This is only required if the named corporation on the application is incorporated outside of California.*
5. Operating Agreement: Current business operating agreement for the applicant business.

C6 Trust In addition to items listed in Sections A and D submit the following:

1. Personal Background Affidavit (17A-37):
 - Trustee(s)
2. Business Background Affidavit (17A-18):
 - The applicant business
3. Trust Document: Provide a copy of the trust or documentation signed under penalty of perjury by the authorized representative of the trust that lists the name(s) of the trustee(s) and beneficiaries, including the percentages of their interest in the trust.

Section D Fingerprint Requirements (All Applicants)

Each person who is required to complete a Personal Background Affidavit (as instructed in Section C) 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 hypodermic needle and syringe license and has electronic fingerprints already on file with the California State Board of Pharmacy, new fingerprints may not be required.*

ALL applicants including nonprofit organizations must complete the fingerprint requirement. (Government owned facilities are exempt from this requirement.)

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

- California residents must use Live Scan. Nonresidents can visit California to complete a Live Scan or submit fingerprints on cards supplied by the Board. The fingerprint cards must be processed at a location authorized to complete fingerprint cards for the DOJ/FBI (e.g. law enforcement agency) in the state the services are rendered.
- DO NOT complete the Live Scan service or fingerprint cards until the applicant is ready to send in the application.
- The Live Scan site may charge a processing fee.
- Fingerprint card processing fee is \$49 per person (\$32 DOJ and \$17 FBI) made payable to the Board of Pharmacy.
- The board will accept fingerprint responses only from the California Department of Justice (DOJ) and Federal Bureau of Investigation (FBI).

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

- California residents must use Live Scan only.
- To find a Live Scan location, go to <https://oag.ca.gov/fingerprints/locations>
- The individual being fingerprinted must ensure the following information is correct when completing the Live Scan:
 - **Type of License/Certification/Permit or Working Title:** Hypodermic – Section 4205

- **Full Name:** Must be EXACTLY THE SAME as the individual's name on his/her state-issued driver's license or state-issued identification card (Jr., II, etc., must be included). It also must be EXACTLY THE SAME as the individual's name on the application.
- **Date of Birth:** Do not omit. If left blank, he/she may have to reprint.
- **Social Security Number (SSN):** If left blank, he/she may have to reprint.
- **Level of Service:** Must include both DOJ and FBI.

B. Non-California Resident: The individual 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 with the application 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 individual being fingerprinted (\$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 card processing fee(s).
- Print legibly or type personal information on the fingerprint cards. If the personal information of the individual being fingerprinted is not legible and DOJ enters the information incorrectly, he/she will be responsible to submit new fingerprint cards and pay the \$49 fingerprint card processing fee again. DOJ will NOT correct print results due to illegible fingerprint cards.
- The fingerprint cards must be processed at a location authorized to complete fingerprint cards for the DOJ/FBI (e.g. law enforcement agency) in the state the services are rendered.
- 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.

5. Change of Ownership or Location Provide the exact name, address, location, and license number as listed on the current hypodermic needle and syringe license.

Name listed on the Current License

License Number

Address: Street

City

State

Zip Code

Expiration Date of License

Effective Date of Change of Ownership/Location

6. Applicant Business Operations

Identify the type of business to be conducted at this location:

____ Veterinary Supply

____ Other, please identify _____

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

7. Ownership Information

California Business and Professions Code section 4035 specifies "person" includes firm, association, partnership, corporation, limited liability company, state governmental agency, trust, or political subdivision.

The application shall provide information to identify the ownership of the applicant business. This may include a parent company as well as each officer, partner and member (as appropriate) for the applicant business. Please provide an organizational chart that clearly documents the applicant business' ownership structure, including percentages owned by all parties.

Complete and submit a Business Background Affidavit (17A-18) for an entity listed under this section signed by its authorized agent. Any natural person listed on the application needs to complete and submit a Personal Background Affidavit (17A-37).

The board may require additional documentation to confirm or substantiate the reported ownership structure at any time during the application process.

Entities:

If the applicant business is owned by an entity (not a natural person), identify each parent entity that has beneficial interest and has management and control of the applicant business, and identify its authorized agent. The authorized agent shall be an officer, partner, member, owner, or trustee of the parent business who is authorized to bind the business. Please submit a Business Background Affidavit form (17A-18) for each entity listed.

Name of Partnership	% Owned	Telephone Number
----------------------------	----------------	-------------------------

Name of Authorized Agent	Telephone Number
--------------------------	------------------

Name of Partner 1	% Owned	Telephone Number
--------------------------	----------------	-------------------------

Name of Authorized Agent	Telephone Number
--------------------------	------------------

Name of Partner 2	% Owned	Telephone Number
--------------------------	----------------	-------------------------

Name of Authorized Agent	Telephone Number
--------------------------	------------------

Name of Corporation	% Owned	Telephone Number
----------------------------	----------------	-------------------------

Name of Authorized Agent	Telephone Number
--------------------------	------------------

Name of Limited Liability Company	% Owned	Telephone Number
--	----------------	-------------------------

Name of Authorized Agent	Telephone Number
--------------------------	------------------

Name of Trust	% Owned	Telephone Number
----------------------	----------------	-------------------------

Name of Authorized Agent	Telephone Number
--------------------------	------------------

Natural Person(s): LIST ALL TITLES, IF SERVING IN MORE THAN ONE CAPACITY.

Provide the name(s) of each owner, partner, member, stockholder, or trustee who is a natural person of the applicant business. If there are no natural person(s) under the applicant business, list the owner(s), partner(s), member(s), stockholder(s), or trustee(s) who are natural persons for the parent business as listed in the Entities section. Natural persons identified shall be authorized to act for and bind the applicant business.

Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership

Executive Officer(s) Information LIST ALL TITLES, IF SERVING IN MORE THAN ONE CAPACITY.

Provide the name(s) of the top five executive officer(s) for the applicant business. If there are no officers of the applicant business, list the top five officer(s) for the parent business as listed in the Entities section.

Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership

APPLICANT AFFIDAVIT - Read carefully and sign below.

This application must be approved by the California State Board of Pharmacy before a hypodermic needle and syringe license will be issued. The applicant business shall not conduct business in California until a license is issued. If changes are made during the application process, the applicant may need to submit a new application with appropriate fees.

Any application not completed within 60 days after being notified by the board of deficiencies may be deemed to have been abandoned, and the applicant will be required to file a new application and meet all the requirements that are in effect at the time of application. Fees applied to this application are not transferable or refundable.

Failure to provide any of the requested information may result in the application being considered incomplete. Any material misrepresentation in the answer of any question is grounds for denial or subsequent revocation of the license and is a violation of the California Penal Code.

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 at the California State Board of Pharmacy. The 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 and exempted by Civil Code section 1798.38.

NOTICE: 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.

REQUIRED SIGNATURES BELOW

The required signatures include the authorized agent for the entity ownership as well as the individual owner, partners, executive officer(s), member(s), manager(s), or trustee(s) who are authorized to bind the applicant business listed on the application.

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

- 1) Is the **owner, partner, member, manager, officer, trustee, or director** of the applicant business named in the foregoing application, 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 attests to the truth and accuracy of all statements, answers, and representations made in this application, including all supplementary statements.;
- 3) No person other than the applicant or applicants has any direct or indirect interest or management and control in the applicant a hypodermic needle and syringe to be conducted under the license for which this application is made;
- 4) Understands that falsification of any information in this application may constitute grounds for denial or subsequent revocation of the license; and
- 5) A change of ownership application may be withdrawn by either the applicant or the licensee with no resulting liability to the California State Board of Pharmacy.

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

Signature	Name (please print)	Title	Date
Signature	Name (please print)	Title	Date
Signature	Name (please print)	Title	Date
Signature	Name (please print)	Title	Date
Signature	Name (please print)	Title	Date
Signature	Name (please print)	Title	Date

AUTHORIZATION TO RELEASE APPLICANT INFORMATION
(Optional)

Applicant Business Information – Please print or type

File Number, if applicable _____

Name of Business Telephone Number of Business

Name of Business DBA if different than above

Address of Business – Street City State Zip Code

The board will ONLY discuss the status of this application with the authorized person identified on the application and any person who has signed the application as an officer, partner, member, and/or owner of the applicant business. In order for the board to discuss the status of this application with another individual, the authorized person identified on the application must authorize in writing the board to discuss the application status with a his or her authorized representative.

Giving consent for the board to disclose application and business information will authorize the board to disclose all personal and business information pertaining to this application. This includes but is not limited to social security number, date of birth, address information, all application requirement information, application approval or denial status, and any criminal conviction information the board may have on record for your application.

Applicant Consent – Must be signed and dated by the applicant for optional authorization to be valid.

As a person identified on the application that is authorized to act for and bind the applicant business, I hereby give the board consent to communicate to the individual listed below.

I, _____, hereby give consent to

Print Name of Person Authorized to Bind the Applicant Business

the California State Board of Pharmacy to disclose information about this application as specified above to the following individual:

Name Telephone Number Email Address

Mailing Address – Street City State Zip Code

This consent will expire on _____, within one year, or upon
licensure, whichever comes first. (Date)

Original Signature of Person Authorized to Bind the Applicant Business Date



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 THE FOLLOWING QUESTIONS (Attach additional sheets of paper if necessary)

- 1. If you are currently licensed as a physician, podiatrist, dentist, optometrist, or veterinarian in any state, territory, foreign country, or other jurisdiction, please provide the following information.

Table with 5 columns: State, License Type and Number, Active or Inactive, Issued Date, Expiration Date

2. If 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.)

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.

6. Criminal Record History

Applicants who answer "No" to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application.

To assist in the timely processing of your application, for each conviction, submit: 1) certified copies of the arresting agency records, 2) certified copies of the court documents (court docket), 3) a signed and dated descriptive explanation of the circumstances surrounding the conviction (i.e., dates and location of the incident and all circumstances surrounding the incident), and 4) proof of compliance with probation or parole. If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is recommended. In addition, you may submit evidence of rehabilitation or any information you deem appropriate.

- A. Have you EVER been convicted of, or pleaded guilty or nolo contendere/no contest to, ANY crime, in any state, the United States or its territories, a military court, or any foreign country?
This includes any felony or misdemeanor offense and any infraction. You must disclose a conviction even if it was: (1) later dismissed or expunged pursuant to Penal Code section 1203.4 or an equivalent release from penalties and disabilities provision from a non-California jurisdiction, or (2) later dismissed or expunged pursuant to Penal Code section 1210.1 or an equivalent post-conviction drug treatment diversion dismissal provision from a non-California jurisdiction.

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

Yes ___ No ___

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

B. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?

Yes ____ No ____

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

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, telephone (916) 574-7900, 1625 N. Market Blvd., Suite N219, Sacramento, CA 95834. This information may be transferred to another governmental agency, such as a law enforcement agency, if necessary 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.

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

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



BUSINESS BACKGROUND AFFIDAVIT

This form is completed for the applicant business and signed by the owner, officer, member, or stockholder of that business. This form is also completed for any entity that owns the applicant business and signed by the authorized agent. The authorized agent must be authorized to act for and bind the company. All blanks must be completed; if not applicable enter "N/A.". 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.

Please identify the business this form is being completed for: **A. Applicant Business** _____
B. Owner/Parent _____

A. Applicant Information

 Name of Applicant Business

 Address of Applicant Business Street City State Zip Code

Position with the Applicant Business is: (Check all that apply)
 _____ Owner _____ Partner _____ Officer _____ Stockholder _____ Member
 _____ Government Representative _____ Administrator _____ Trustee
 _____ Other, please specify the position _____

B. Name of Owner

 Name of Parent Entity listed as Owner on Application

 Address Street City State Zip Code

 Email Address Telephone Number

 Name of Authorized Agent Telephone Number

Authorized Agent's position with this business is:
 _____ Owner _____ Executive Officer _____ Member _____ Manager _____ Principal _____ Other Specify _____

1. Is this business currently, or has it in the previous five years, been an owner, member, or partner of any partnership, corporation, firm, or association whose application for a license has been denied or whose license has been revoked, suspended, or been placed on probation in California or any other state? **Yes** ___ **No** ___ If Yes, provide the following information for each action taken, including licenses cancelled. (Use additional sheets if necessary)

State	Company Name	Type of License & License Number	Position Held	Type of Action	Year of Action

2. Has this business ever been in violation of any provisions of California pharmacy law, including regulations? **Yes** ___ **No** ___ If "yes," list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.)

State	Company Name	Type of License & License Number	Position Held	Type of Action	Year of Action

3. Has this business 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? This includes 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 1210.1 or 1203.4. **Yes** ___ **No** ___

Applicant Affidavit Please read carefully and sign below.

I hereby certify and affirm under penalty of perjury, under the laws of the State of California, that: (1) I am a person authorized to act for and bind the applicant and I am at least 18 years of age; (2) I have read the foregoing background certification and know the contents thereof and each and every statement made therein is true; (3) I understand that falsification of any information in this affidavit may constitute grounds for denial or subsequent revocation of the license; (4) no other 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 affidavit is made; all supplemental statements filed with this affidavit are true, complete and accurate.

Original Signature

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



SELLER'S CERTIFICATION

INSTRUCTIONS: This form is to be completed by the seller and submitted with the application for a change of ownership by the prospective owner. A copy of the pending purchase agreement must be attached. Please print or type.

NOTICE: The license is not transferable, and the current owner of record must maintain operations and control of the licensed premises (including renewing the license) until the change of ownership is approved by the California State Board of Pharmacy. Proof of authority to sell by any person, other than a person whose name appears on the California State Board of Pharmacy license record, must accompany this certification.

This will certify that _____
 Name of Seller

has agreed that on _____ Seller shall transfer _____
 month/day/year (all, half, etc.)

of the right, title and interest in _____
 Name of Facility License Number

Located at _____
 Address City State Zip Code

List the Name of all Buyer(s)

On completion of this sale and approval of the new license, the original license, and the current renewal must be returned to the California State Board of Pharmacy.

Under penalty of perjury under the laws of the State of California, each person whose signature appears below certifies and says that (If the seller is a partnership, all partners must sign below):

1. Is the licensee, named in this Seller's Certification, duly authorized to make this sale;
2. Is listed on the current license; and
3. All statements made in this Seller's Certification are true and correct.

Signature of Seller	Name (please print)	Title	Date
Signature of Seller	Name (please print)	Title	Date
Signature of Seller	Name (please print)	Title	Date

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

California 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.



REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI (Code assigned by DOJ)

Authorized Applicant Type

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

Contributing Agency Information:

Agency Authorized to Receive Criminal Record Information

Mail Code (five-digit code assigned by DOJ)

Street Address or P.O. Box

Contact Name (mandatory for all school submissions)

City State ZIP Code

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 (Other Identification Number)

Home Address Street Address or P.O. Box

City State ZIP Code

Your Number: 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):

Employer Name

Mail Code (five digit code assigned by DOJ)

Street Address or P.O. Box

City State ZIP Code

Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency LSID

ATI Number Amount Collected/Billed