



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

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

## CHANGE OF PHARMACIST-IN-CHARGE

Both the owner of a pharmacy and the pharmacist-in-charge are required by California law to notify the Board of Pharmacy within 30 days after the termination of the pharmacist-in-charge. Failure to make this notification to the board may result in disciplinary action.

To properly notify the board of a change in pharmacist-in-charge, the following items must be submitted:

- Completed Change of Pharmacist-in-Charge form
- \$100 fee (excluding clinics, non-resident pharmacies and government owned facilities)
- Certification of Personnel for NEW pharmacist-in-charge only

(Please print or type)

### ALL SECTIONS MUST BE COMPLETED

Name of pharmacy:		Telephone	Pharmacy permit number		
Address of pharmacy:		Street	City	State	Zip
List below the name, license number and address of the new pharmacist-in-charge:					
Name				Pharmacist license number	
Home address		Street	City	State	Zip
Effective date					
List below the name, license number and address of the pharmacist-in-charge being replaced:					
Name				Pharmacist license number	
Home address		Street	City	State	Zip
Date of disassociation					

***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.***

\_\_\_\_\_  
 Signature of owner, partner or corporate officer

\_\_\_\_\_  
 Typed or printed name and title

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of new pharmacist-in-charge

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of pharmacist-in-charge being replaced  
 (if available)

\_\_\_\_\_  
 Date

Cashier # _____
Date _____
Amount _____



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

## CERTIFICATION OF PERSONNEL

**INSTRUCTIONS: Must be completed by each owner, director, officer, major shareholder and pharmacist-in-charge.**

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

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

3. Are you currently licensed as a physician, podiatrist, dentist, optometrist or veterinarian in this state or any other state? If the answer is "yes," please list each license number, license type, and the state(s) where you are licensed.  Yes  No

License Type	License Number	State	Expiration Date

4. Is your spouse, child, parent, or other relative or any person with whom you share a financial interest, licensed in this state or any other state, as a physician, podiatrist, dentist, or veterinarian? If the answer is "yes," list the name of each person, their relationship to you, the license type, number and state. (Use additional sheets if necessary.)  Yes  No

Name	Relationship	License Type	License Number	State

5. Are you currently, or have you previously been, listed as a corporate officer, partner, owner, manager, limited liability company member, administrator or medical director on a permit to sell, store or possess dangerous drugs or dangerous devices in this state or any other state? If "yes," please list the company name, permit type and number, position(s) held, state and expiration date. Please include information regarding cancelled permits. (Use additional sheets if necessary.)  Yes  No

Name of company	Type of permit	Permit number	Position held	State	Expiration date

6. Have you ever had a pharmacy permit, or any professional or vocational license or registration denied, suspended, revoked, placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state? If "yes," please provide permit type, action, company name (if applicable), year of action and state. (Use additional sheets if necessary.)  Yes  No

Name of person or business	Type of permit	Type of Action	Year of Action	State

7. Are you currently, or have you previously been, associated in business with any person, partnership, corporation, or other entity, or shared a financial or community property interest with any person whose pharmacy permit, or any professional or vocational license was denied, suspended, revoked, or placed on probation or other disciplinary action taken, by this or any other governmental authority in this state or any other state? If the answer is "yes," please list the company name, permit type, action, year of action and state. (Use additional sheets if necessary.)  Yes  No

Name of person or business	Type of permit	Type of Action	Year of Action	State

8. Have you ever been in violation of any provisions of pharmacy law, in this or any other state? If "yes," please list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.)  Yes  No

Name of person or business	Type of permit	Type of Action	Year of Action	State

9. Have you ever been convicted of, or pled no contest to, a violation of any law of a foreign country, the United States, any state or local jurisdiction? You must include all misdemeanor and felony convictions, regardless of the age of the conviction, including those which have been set aside and/or dismissed under Penal Code section 1000 or 1203.4. (Traffic violations of \$500 or less need not be reported.) If "yes," please attach an explanation which must include the type of violation, the date, circumstances and location, and the complete penalty received.  Yes  No

10. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety without exposing others to significant health and safety risks?  Yes  No

If "yes," attach a statement of explanation. If "no," go directly to question 12.

11. Are the limitations caused by your medical condition reduced or improved because you receive ongoing treatment or participate in a monitoring program?  Yes  No  
If "yes," please attach a statement of explanation.

(If you do receive ongoing treatment or participate in a monitoring program, the board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, or whether conditions should be imposed).

12. Do you currently engage in, or have been engaged in the past two years, in the illegal use of controlled substances?  Yes  No  
If " yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to ensure that you are not engaging in the illegal use of controlled substances? **Please attach a statement of explanation.**

13. Will you work as an employee of this business? If yes, what will your responsibilities and duties be with this business?  Yes  No

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**You must provide a written explanation for all affirmative answers to questions 3 - 12. Failure to do so may result in this application being deemed withdrawn as incomplete.**

If you are a non-pharmacist owner, partner, corporate officer, corporate director or administrator of the business, you should be aware that:

- (a) any non-pharmacist owner who commits any act which would subvert or tends to subvert the efforts of the pharmacist-in-charge to comply with the laws governing the operation of the pharmacy is guilty of a misdemeanor;
- (b) you may not order a pharmacist to perform any act which is prohibited by law;
- (c) any violation of the Federal Food, Drug & Cosmetic Act, the Federal Controlled Substance Act or any law or regulation relating to the practice of pharmacy in the State of California is grounds for suspension or revocation of the permit for which you are applying;
- (d) committing any act prohibited by law, or neglecting to perform any duty required by law, could result in proceedings against the personal license of a pharmacist or could result in an action against your permit.
- (e) you are not permitted to assist in any phase of compounding or dispensing of prescriptions, or to perform any of the duties which are required by law or regulation to be done by a pharmacist;
- (f) only a pharmacist may possess the key to the pharmacy or to the permanent barrier separating the pharmacy;
- (g) you may enter the pharmacy for the purpose of performing certain specified duties only when the pharmacist is present; and the pharmacist is responsible for any non-registered person allowed to enter the pharmacy. (This does not apply to hospital pharmacies or limited permits under Business and Professions Code section 4117, or Title 16, California Code of Regulations section 1714);
- (h) dangerous drugs and/or devices as defined in Business and Professions Code sections 4022 and 4023 may only be sold on prescription or to persons who are licensed to handle, sell and possess such drugs.

All items of information requested on this form are mandatory. Failure to provide any of the requested information will result in the application being deemed withdrawn as incomplete. This information will be used to determine qualifications for licensure under California pharmacy law. The officer responsible for information maintenance is the executive officer, telephone (916) 574-7900, 1625 N. Market Blvd, Suite N219, Sacramento, CA 95834. This information may be transferred to another governmental agency, such as a law enforcement agency, if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by Civil Code section 1798.3.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing certification of personnel form, including all supplementary statements ,and I personally completed this certification of personnel form.

I also certify that I have read and understand the rules of professional conduct and have retained a copy on file.

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Signature

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Date