



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 SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

DESIGNATED REPRESENTATIVE* REQUIREMENTS AND APPLICATION

A designated representative* is an individual who performs clerical, inventory control, housekeeping, delivery, maintenance, or similar functions related to the distribution or dispensing of dangerous drugs or dangerous devices. To work as a designated representative, you must possess and keep a current certificate as a designated representative.

DESIGNATED REPRESENTATIVE CERTIFICATION REQUIREMENTS

An individual applying to become a designated representative shall meet the following requirements:

- ♦ Be a high school graduate or possess a general education development equivalent,
- ♦ Have a minimum of one year of paid work experience related to the distribution or dispensing of dangerous drugs or dangerous devices **or** meet all of the prerequisites to take the examination required for licensure as a pharmacist by the board, and
- ♦ Complete a training program that, at a minimum, addresses each of the following subjects:
 - (A) Knowledge and understanding of California and federal law relating to the distribution of dangerous drugs and dangerous devices.
 - (B) Knowledge and understanding of California and federal law relating to the distribution of controlled substances.
 - (C) Knowledge and understanding of quality control systems.
 - (D) Knowledge and understanding of the United States Pharmacopoeia standards relating to the safe storage and handling of drugs.
 - (E) Knowledge and understanding of prescription terminology, abbreviations, dosages and format.

HOW TO APPLY TO BECOME A DESIGNATED REPRESENTATIVE

Your application must include:

- A non-refundable application fee of \$255.
- A completed *Application for A Designated Representative License* (17A-E), with all questions answered. You must sign this form and attach a photograph, scanned photos are not acceptable.
- A completed *Designated Representative Experience Declaration* (17A-E2)
- A completed *Designated Representative Training Declaration* (17A-E3)
- A copy of Request for Live Scan Service Form verifying that your fingerprints have been scanned and all applicable fees paid or a set of two completed fingerprint cards and the fingerprint processing fee of \$51.00. (See "Fingerprint Requirements" on next page)
- If you would like notification that the board has received your application, please submit a stamped postcard addressed to yourself.

It takes approximately ten weeks to issue a designated representative license after submission of a complete and acceptable application package. The board will notify you if additional information is needed to process your application package.

Fingerprint Requirements

California Residents

The board will only accept Live Scan Service Forms from California residents. Live Scan will be accepted from residents of other states if the Live Scan service is performed in California. The board will only accept fingerprint cards from residents outside of California.

Complete a Live Scan Request form and take all 3 copies to a Live Scan site for fingerprint scanning. Please refer to the Instructions for completing a "Request for Live Scan Service" form. Live Scan sites are located throughout California. For more information about locating a Live Scan site near you, visit the Department of Justice website at <http://ag.ca.gov/fingerprints/publications/contact.htm> or the sources listed on the bottom of the instructions for completing a "Request for Live Scan Service" form.

The lower portion of the Live Scan Request form must be completed by the Live Scan operator verifying that your prints have been scanned and all applicable fees have been paid. Attach the second copy of the form to your application and submit to the board.

Note to Applicants Submitting Fingerprints Via Live Scan: While the Live Scan forms contained in the board's application package are pre-slugged to indicate level of service at the DOJ and FBI level, please ensure at the time of Live Scan transmission that the Live Scan operator selects both the DOJ and FBI levels of service. If FBI is not selected at the time of original transmission, you may be required to have your Live Scan redone at another time and have to 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.

Non California Residents

If a designated representative resides out of state they must submit rolled fingerprints on cards provided by the board and include a separate fee of \$51 (\$32 California Department of Justice (DOJ) fee, and \$19 FBI fingerprint processing fee). (Live Scan processing fees are paid directly at the Live Scan site.) You may contact the board to request fingerprint cards at (916) 574-7900. You may also request cards on our website at www.pharmacy.ca.gov.

Fingerprints submitted on cards should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take approximately six weeks. Poor quality prints may result in rejection and will substantially delay licensing as additional fingerprint cards will be required from you for processing.



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

APPLICATION FOR A DESIGNATED REPRESENTATIVE* LICENSE

Print or type

Name: Last First Middle Former					TAPE A PHOTOGRAPH TAKEN WITHIN 60 DAYS OF THE FILING OF THIS APPLICATION NO POLAROID OR SCANNED IMAGES
**Address of record: Number		Street			
City		State		Zip Code	
Residence Address: (if different from above) Number		Street			
City		State		Zip Code	
Home telephone number: ()		Work telephone number: ()		Fax Number: ()	
Email address:		Date of Birth		Social Security Number ***	
EDUCATION					
Name of high school attended _____ Location of school (city & state) _____					
Graduate from high school? Yes <input type="checkbox"/> Date: _____ GED _____ Date: _____					
Name that appears on diploma or GED certificate: _____					
PHARMACIST EXAM					
Are you eligible to take the California pharmacist licensure exam? Yes <input type="checkbox"/> No <input type="checkbox"/>					
If "yes," provide the date you applied: _____ Name applied under: _____					

*Note: Under California law, the name used to describe any individual who is in charge of any wholesale drug premises (in California or elsewhere) will change on January 1, 2006, from the former name, *exemptee*, to *designated representative*. For conventional use, the board will refer to such an individual as a *designated representative* throughout this application.

** Once you are licensed with the board the address of record you enter on this application is considered public information pursuant to the Information Practices Act (Civil Code section 1798 et seq.) and the Public Records Act (Government Code section 6250 et seq.) and will be placed on the Internet upon licensure. If you do not wish your residence address to be available to the public, you may provide a post office box number or a personal mail box (PMB). However, if your address of record is a box number you must also provide your residence address as an alternate address that will not be available to the public.

DO NOT WRITE BELOW THIS LINE				
Live Scan	<input type="checkbox"/>	Training cert	<input type="checkbox"/>	Certification No. _____
Photo	<input type="checkbox"/>	Hours verified	_____	Application fee no. _____
Exp Aff	<input type="checkbox"/>	Enforce	<input type="checkbox"/>	Date Issued _____
FP Clearance	<input type="checkbox"/>	_____		Amount _____
				Date Cashiered _____

You must provide a written explanation for all affirmative answers. Failure to do so may result in this application being deemed incomplete.

1. Do you currently engage, or have you been engaged in the past two years, in the illegal use of controlled substances? Yes No

If “yes,” are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? **Attach a statement of explanation.**
2. Has disciplinary action ever been taken against your pharmacist license, intern permit or exemption certificate in this state or any other state? **If “yes,” attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.** Yes No
3. Have you ever had an application for a pharmacist license, intern permit or exemption certificate denied in this state or any other state? **If “yes,” attach a statement of explanation to include circumstances, type of action, date of action and type of license, registration or permit involved.** Yes No
4. Have you ever had a pharmacy permit, or any professional or vocational license, certification or registration denied or disciplined by a governmental authority in this state or any other state? **If “yes,” provide the name of company, type of permit, type of action, year of action and state.** Yes No
5. Have you ever been convicted of or pled no contest to a violation of any law of a foreign country, the United States or any state laws or local ordinances? You must include all misdemeanor and felony convictions, regardless of the age of the conviction, including those which have been set aside under Penal Code sections 1000 or 1203.4. Traffic violations of \$500 or less need not be reported. **If “yes,” attach an explanation including the type of violation, the date, circumstances, location and the complete penalty received.** Yes No
6. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator or medical director on a permit to conduct a pharmacy, wholesaler, or any other entity licensed in this state or any other state? If yes, provide company name, type of permit, permit number and state where licensed. Yes No
7. Do you have, or have you had in the last 5 years, any direct or indirect beneficial interest in any other premises licensed by the Board of Pharmacy? Yes No
8. Have you ever been in violation of any provisions of pharmacy law? Yes No
9. Are you currently or have you previously been associated in business with any person, partnership, corporation or other entity, or shared a financial or community property interest with any person whose permit or any professional or vocational license was denied, suspended, revoked, or placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state by a federal regulatory agency? Yes No

Please read carefully and sign below.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license. I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in this application, including all supplementary statements. I also certify that I personally completed this application and have read and understand the instructions attached to this application.

Signature of applicant (in full—no initials)

Date signed

***Disclosure of your social security number is mandatory. Business and Professions Code section 30 and Public Law 94-455 (42 USCA 405(c)(2)(C) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes of compliance with any judgement or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code. If you fail to disclose your social security number, your application for license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

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, telephone (916) 574-7900, 1625 N. Market Blvd, Suite N219, Sacramento, California 95834. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on them by our agency, unless the records are identified as confidential information and exempted by Civil Code section 1798.3.

MANDATORY REPORTER

Under California law each person licensed by the Board of Pharmacy is a "mandated reporter" for both child and elder abuse or neglect purposes.

California Penal Code section 11166 and Welfare and Institutions Code section 15630 require that all mandated reporters make a report to an agency specified in Penal Code section 11165.9 and Welfare and Institutions Code section 15630(b)(1) [generally law enforcement, state, and/or county adult protective services agencies, etc...] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child, elder and/or dependent adult whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or elder abuse or neglect. The mandated reporter must contact by telephone immediately or as soon as possible, to make a report to the appropriate agency(ies) or as soon as is practicably possible. The mandated reporter must prepare and send a written report thereof within two working days or 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of Section 11166 and Section 15630 is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars (\$1,000), or by both that imprisonment and fine.

For further details about these requirements, consult Penal Code sections 11164 and Welfare and Institutions Code section 15630, and subsequent sections.



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

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

DESIGNATED REPRESENTATIVE* TRAINING DECLARATION

TO BE COMPLETED BY APPLICANT

(Please print or type)

Name of Applicant	Last	First	Middle	Former
Residence Address	Number and Street		City	State
Home telephone number		Work telephone number		
Zip Code				

TO BE COMPLETED BY THE PERSON HAVING DIRECT KNOWLEDGE OF APPLICANT'S TRAINING

The individual applying for certification as a designated representative in California has completed training required by Section 4053 of the California Business and Professions Code that addressed, at a minimum:

- Knowledge and understanding of California and federal laws regarding the distribution of dangerous drugs and dangerous devices;
- Knowledge and understanding of California and federal laws regarding the distribution of controlled substances;
- Knowledge and understanding of United States Pharmacopoeia standards for the safe storage and handling of drugs;
- Knowledge and understanding of quality control systems; and
- Knowledge and understanding of prescription terminology, abbreviations, dosages and format.

THIS TRAINING WAS PROVIDED BY

(Please print or type)

Name of company, school or individual providing the training				
Name of Person Having Direct Knowledge of Training				
Address	City	State	Zip Code	Telephone Number

From _____ to _____ Number of hours _____
 (month/day/year) (month/day/year)

DO NOT use "current, present or still employed" (use exact dates)

I declare under penalty of perjury under the laws of the State of California that all statements given herein are true and correct.

 Signature of Person Having Direct Knowledge of Applicant's Training

 Position

 Date

*Note: Under California law, the name used to describe any individual who is in charge of any wholesale drug premises (in California or elsewhere) will change on January 1, 2006, from the former name, *exemptee*, to *designated representative*. For conventional use, the board will refer to such an individual as a *designated representative* throughout this application.



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

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

DESIGNATED REPRESENTATIVE EXPERIENCE DECLARATION

TO BE COMPLETED BY APPLICANT

(Please print or type)

Name of Applicant	Last	First	Middle	Former
Residence Address	Number and Street	City	State	Zip Code
Home telephone number		Work telephone number		

TO BE COMPLETED BY THE PERSON HAVING DIRECT KNOWLEDGE OF APPLICANT'S EXPERIENCE

(Please print or type)

_____ (Name of Applicant)

was employed for at least one year of paid experience related to the distribution or disposition of dangerous drugs or dangerous devices.

from _____ to _____ Number of years _____
 (month/day/year) (month/day/year)

DO NOT state "current, present or still employed" (use exact dates)

NAME AND ADDRESS OF EMPLOYER

Name of Business	Board of Pharmacy License Number			
Address	Number and Street	City	State	Zip Code
Name of Person Having Direct Knowledge (please print)			Telephone Number	

I declare under penalty of perjury under the laws of the State of California that all statements given herein are true and correct.

 Signature of Person Having Direct Knowledge
 of Applicant's Work Experience

 Position

 Date

**INSTRUCTIONS FOR COMPLETING A
"REQUEST FOR LIVE SCAN SERVICE" FORM
(California Residents)**

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly; failure to do so may result in processing delays of your application.

NOTE TO APPLICANT and LIVE SCAN OPERATOR: The applicant's name, date of birth and US Social Security Number must be entered in at the time of the Live Scan transmission in order for the results to be accepted by the Board of Pharmacy. If any of the applicant's name, date of birth or US Social Security Number are not entered at the time of Live Scan transmission, the applicant may have to have a new Live Scan transmission completed.

1. **Job Title or Type of License, Certification, or Permit:** Enter the type of license, certification or permit for which you are applying. Appropriate license types include pharmacist, pharmacy technician, intern pharmacist, exemptee, or if an owner or officer of a pharmacy, hospital, clinic, wholesaler or hypodermic permit enter appropriate title of the facility.
2. **Name of Applicant:** Enter your last name, first name and middle name. Do not use initials or name abbreviations.
3. **AKA:** Enter all other names you have used, including your maiden name.
4. **CDL No:** Your California Driver's License Number.
5. **DOB:** Your date of birth (month/day/year).
6. **SEX:** Your gender (male or female).
7. **HT:** Your height in feet and inches.
8. **WT:** Your weight in pounds.
9. **Misc. No.:** Enter other identifying numbers. (e.g., Other State Driver's License Number)
10. **EYE Color:** Color of your eyes
11. **HAIR Color:** Color of your hair
12. **Home Address:** Your residence address
13. **POB:** Enter your place of birth.
14. **SOC:** Enter your Social Security Number
15. **Level of Service:** While the Live Scan forms contained in the board's application package are pre-plugged to indicate level of service at the DOJ and FBI level, please ensure at the time of Live Scan transmission that the Live Scan operator selects both the DOJ and FBI levels of service. If FBI is not selected at the time of original transmission, you may be required to have your Live Scan redone at another time and have to 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.

Take the completed form to your nearest Live Scan site for fingerprint scanning. There are more than 130 Live Scan sites throughout the state. An up-to-date Live Scan site list is on the Department of Justice's (DOJ) Internet web page at <http://ag.ca.gov/fingerprints/publications/contact.htm> or call your local police or sheriff's department.

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (DOJ processing fee of \$32, FBI processing fee of \$19, and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about \$5 to \$20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs. The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

FINGERPRINTING AUTHORITY

Section 144(b) of the Business and Professions Code authorizes the Board of Pharmacy to require an applicant for licensure to furnish a full set of fingerprints for purposes of conducting criminal history record checks. Fingerprints are required in order for the DOJ/FBI to conduct background checks for criminal convictions.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: _____ Type of Application: (check one) Employment License, Certification, Permit Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

Agency authorized to receive criminal history information _____ Mail Code (five-digit code assigned by DOJ) _____
Street No. _____ Street or PO Box _____ Contact Name (Mandatory for all school submissions) _____
City _____ State _____ Zip Code _____ () _____
Contact Telephone No. _____

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____ CDL No. _____
Last First

DOB: _____ SEX: Male Female Misc. No. **BIL** - _____
Agency Billing Number (if applicable)

HT: _____ WT: _____ Misc. No. _____

EYE Color: _____ HAIR Color: _____ Home Address: _____

POB: _____ Street or PO Box _____

SOC: _____ City, State and Zip Code _____

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ FBI

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

Employer Name _____

Street No. _____ Street or PO Box _____ Mail Code (five digit code assigned by DOJ) _____

City _____ State _____ Zip Code _____ () _____
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency _____ ATI No. _____ Amount Collected/Billed _____

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: _____ Type of Application: (check one) Employment License, Certification, Permit Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

Agency authorized to receive criminal history information _____ Mail Code (five-digit code assigned by DOJ) _____
Street No. _____ Street or PO Box _____ Contact Name (Mandatory for all school submissions) _____
City _____ State _____ Zip Code _____ () _____
Contact Telephone No. _____

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____ CDL No. _____
Last First

DOB: _____ SEX: Male Female Misc. No. **BIL** - _____
Agency Billing Number (if applicable)

HT: _____ WT: _____ Misc. No. _____

EYE Color: _____ HAIR Color: _____ Home Address: _____

POB: _____ Street or PO Box _____

SOC: _____ City, State and Zip Code _____

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ FBI

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

Employer Name _____

Street No. _____ Street or PO Box _____ Mail Code (five digit code assigned by DOJ) _____

City _____ State _____ Zip Code _____ () _____
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency _____ ATI No. _____ Amount Collected/Billed _____

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: _____ Type of Application: (check one) Employment License, Certification, Permit Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

Agency authorized to receive criminal history information _____ Mail Code (five-digit code assigned by DOJ) _____
Street No. _____ Street or PO Box _____ Contact Name (Mandatory for all school submissions) _____
City _____ State _____ Zip Code _____ () _____
Contact Telephone No. _____

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____ CDL No. _____
Last First

DOB: _____ SEX: Male Female Misc. No. **BIL** - _____
Agency Billing Number (if applicable)

HT: _____ WT: _____ Misc. No. _____

EYE Color: _____ HAIR Color: _____ Home Address: _____

POB: _____ Street or PO Box _____

SOC: _____ City, State and Zip Code _____

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ FBI

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

Employer Name _____

Street No. _____ Street or PO Box _____ Mail Code (five digit code assigned by DOJ) _____

City _____ State _____ Zip Code _____ () _____
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency _____ ATI No. _____ Amount Collected/Billed _____