California State Board of Pharmacy
1625 N. Market Blvd., Suite N-219
Sacramento, CA 95834-6237
Phone (916) 574-7900 Fax (916) 327-6308
www.pharmacy.ca.gov

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

DESIGNATED REPRESENTATIVE-REVERSE DISTRIBUTOR APPLICATION INSTRUCTIONS

A person applying for a designated representative-reverse distributor license must demonstrate he/she meets the requirements for licensure pursuant to Business and Professions Code section 4053.2. A designated representative-reverse distributor license is responsible for supervision over a licensed wholesaler that ONLY acts as a reverse distributor pursuant to Business and Professions Code section 4022.6.

HOW LONG WILL IT TAKE TO PROCESS MY APPLICATION?

- Please allow the board 45 days to process your application.
- You will be notified by mail if your application is not complete.
- Please do not contact the board to check on your application unless it has been on file for over 60 days.
- If your check has cleared your bank, the board has received your application.
- To check if your license was issued, go to www.pharmacy.ca.gov. Select "Verify a License" and enter your name. It takes four to six weeks from the date a license is issued to receive the license in the mail.

WHAT MAKES AN APPLICATION COMPLETE?

Use the check boxes below to be sure your application is complete before mailing it the board.

- If your application is not complete, you will receive a "Deficiency Letter" in the mail.
- You will then have 60 days to submit the required item(s).
- If you do not submit the required item(s) within 60 days, you may have to file a new application with new fees and meet any new requirements.

☐ **APPLICATION FEE $150:** When you send your application, include a check or money order for $150 made payable to the Board of Pharmacy. The application fee is non-refundable.

☐ **APPLICATION FOR A DESIGNATED REPRESENTATIVE-REVERSE DISTRIBUTOR LICENSE** (form 17A-102): Complete the entire application. *A licensed pharmacist is not required to be licensed as a designated representative-reverse distributor to act as a designative representative-in-charge for a wholesaler if he/she is licensed as a pharmacist in the home state in which the wholesale facility is located.*

AVOID COMMON MISTAKES

- **Look at your state issued driver's license or state issued identification card prior to completing the application.** The name on each form listed below must be **EXACTLY THE SAME** as the name on your state issued driver's license or state issued identification card. If you have a hyphenated name, two last names, or two first names, you need to list your name on each of the following documents to match that of your state issued identification:
  - ✓ Designated Representative-Reverse Distributor Application
  - ✓ Request for Live Scan form or fingerprint cards
- Have you ever used a different name? List each prior name on the application under Previous Names.
  - ✓ Did you have a maiden name, married name, former name, AKA?
  - ✓ Have you ever used Jr., Sr., II, etc., with your name?
  - ✓ If you do not list all of your previous names, the board may not be able to locate, match or verify your documents.

- Do not leave anything blank; Use "N/A" if a question doesn't apply to you.
- You must sign and date the application. No one else can sign it for you. Signatures must be original and dated within 60 days of filing the application. No electronic, stamped, copies or faxed signatures will be accepted.

☐ **U.S. Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN):** Disclosure of your U.S. social security number or individual taxpayer identification number is mandatory and must be included on the application.

☐ **PHOTO:** Attach a passport-style photo to page 1 of the application (2"x2" glossy color photo) taken within 60 days of filing the application. **DO NOT** provide scanned images, Polaroids, or black-and-white photos.

☐ **MILITARY EXPEDITE:** The board will expedite review of an application that meets one of the following criteria (A, B, or C).

A. Serving in the Military: Are you currently serving in the United States military?
   - ✓ Please attach some evidence of your current service, such as, a copy of your military identification.

B. Military Veteran: Have you ever served in the United States military? Were you honorably discharged?
   - ✓ Please attach a copy of your DD214 with your application.

C. Active Duty Military-Spouses or Partners: If your spouse or partner is an active duty member of the U.S. Armed Forces and you hold a current license in another state, please provide the following:
   - ✓ A copy of your current license in another state, district, or territory of the United States documenting the profession or vocation for which you seek licensure from the board.
   - ✓ A copy of the marriage certificate, certified declaration/registration of domestic partnership, or other evidence of legal union.
   - ✓ A copy of your spouse or partner's military orders establishing duty station in California.

☐ **BASIC EDUCATION**: You must be a high school graduate or have a general education development certificate equivalent. Attach **ONE** of the following (A, B, C, D, or E):

A. U.S. High School Graduate: Attach an official, embossed transcript (academic record) or notarized copy of your high school transcript. It must have the graduation date on it. To get a copy of your high school transcript, contact your high school or its school district office.
B. Foreign High School Graduate: Attach a notarized copy of your foreign secondary school diploma or certificate **OR** a notarized copy of your foreign secondary school transcripts. If not in English, then include a certified translation in English. The translation may be from an evaluation service that states your education is equal to graduating high school in the U.S.
C. High School Equivalency: Attach 1, 2, or 3 to show documentation of completing one of the three High School Equivalency Tests.
   1. General Educational Development (GED): Attach an official transcript of your test results or equivalent. GED test results are official only if they are earned through an authorized GED Testing Center. To get your GED transcripts, go to http://www.gedtestingservice.com/testers/gedrequest-a-transcript. If your GED is

from another state, you may need to request an official transcript of your GED test results from the agency in that state.

2. HiSET: Attach an official transcript of your test results or equivalent. HiSET test results are official if they are earned through an authorized HiSET Testing Center. To request your HiSET transcripts, go to www.diplomasender.com.
3. TASC: Attach an official transcript of your test results or equivalent. TASC test results are official if they are earned through an authorized TASC Testing Center. To request your TASC transcripts, go to http://www.tasctest.com/.

D. Certificate Equivalent – Attach an official "Certificate of Proficiency" showing you passed the California High School Proficiency Examination (CHSPE). To request a copy, go to https://www.chspe.net/cert-trans/ or call (866) 342-4773.

E. Out-of-State High School General Educational Development Certificate Equivalent: Attach an official transcript of your test results or equivalent.

☐ **REQUIRED EXPERIENCE:** Submit a completed affidavit as instructed in A or attach the required documentation as instructed in B.

A. Designated Representative-Reverse Distributor Experience Affidavit (form 17A-E7): Submit this form.

1. Document completion of a minimum of one year of paid work experience in the past three years, performing duties related to the distribution, dispensing, or destruction of dangerous drugs or dangerous devices in a licensed pharmacy, wholesaler, or third-party logistics provider. Do NOT include all employment dates, only paid work experience dates. An applicant may not sign as the person with direct knowledge of the applicant's experience.
   - If the one year of paid work experience was gained at multiple facilities, submit an experience affidavit form (form 17A-E7) for each facility where paid work experience was gained.
   - If your paid work experience was obtained in a facility not licensed by the California State Board of Pharmacy, you must request a License Verification to be completed by the appropriate authority which licensed the facility.

2. Document completion of a minimum of one year of paid work experience in the destruction of outdated or nonsaleable dangerous drugs or dangerous devices pharmaceutical waste.

B. Eligible for Pharmacist Examination: Include documentation that clearly identifies that you meet the prerequisites to take the examination required for licensure as a pharmacist by the board. This may include your examination eligibility letter that identifies the date you were deemed eligible to sit for the examination.

☐ **REQUIRED TRAINING:** Designated Representative-Reverse Distributor Training Affidavit (form 17A-E8). Submit this form documenting that you have completed a training program pursuant to Business and Professions Code section 4053.2. An applicant may not sign as the person with direct knowledge of the applicant's training.

☐ **VERIFICATION OF LICENSE IN ANOTHER STATE** (form 17A-16)**:** If you are currently licensed or have held a license in another state as a designated representative, intern pharmacist, pharmacist, pharmacy technician, and/or another health care professional, you must request each appropriate state agency to verify your license by completing the required Verification of License in Another State (form 17A-16).

☐ **FINGERPRINTS:**

- California residents must use Live Scan. Non-residents can visit California to complete a Live Scan or must submit professionally rolled fingerprints on cards supplied by the

board.

- **DO NOT** complete the Live Scan service or fingerprint cards until you are ready to send in your application.
- You must submit a copy of your Live Scan receipt or two rolled fingerprint cards with your application.
- Each application requires you to complete a new Live Scan or submit new rolled fingerprint cards.
- The Live Scan site may charge a processing fee.
- The board will accept fingerprint responses only from the California Department of Justice (DOJ) and Federal Bureau of Investigation (FBI).

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

A. California Resident: Attach completed Live Scan receipt. The receipt shows you completed the Live Scan.

- California residents must use Live Scan only.
- To find a Live Scan location, go to https://oag.ca.gov/fingerprints/locations
- Live Scan operators can make mistakes. You should ensure the information the operator enters is correct before they transmit your prints.

Make sure the following information is correct when you complete your Live Scan:

- **Type of License/Certification/Permit or Working Title:** Pharmacy Wholesaler – Section 4305.5.
- **Full Name:** Must be EXACTLY THE SAME as the name on your 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 name on your application.
- **Date of Birth:** Must be correct.
- **Social Security Number (SSN) or Individual Tax Identification Number (ITIN):** Include your SSN or ITIN number. If left blank you may have to reprint. If you have an ITIN, enter this number in the SSN field.
- **Level of Service:** Must include both DOJ and FBI.

B. Non-California Resident: You may visit California and complete Live Scan. If you cannot, then you must submit two rolled fingerprint cards with your application.

- You must use fingerprint cards from the California State Board of Pharmacy.
- Request fingerprint cards through the board's online services at https://www.dca.ca.gov/webapps/pharmacy/pubs_request.php or email rxforms@dca.ca.gov.
- Fee: Include fingerprint card processing fee of $49 ($32 DOJ and $17 FBI), made payable to the Board of Pharmacy.
- You can send one check or money order for both the application processing fee and fingerprint card processing fee.
- Print legibly or type your personal information on the fingerprint cards. If your personal information is not legible and DOJ enters your information incorrectly, you will be responsible to submit new fingerprint cards and pay the $49 fingerprint card processing fee again.
- Fingerprints must be taken by a person professionally trained to roll prints.
- Fingerprint clearances from cards take about six weeks longer than Live Scan.
- Poor quality prints will be rejected and will cause delay because new fingerprint cards will be required.

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DESIGNATED REPRESENTATIVE-REVERSE DISTRIBUTOR LICENSE APPLICATION

Please read the application instructions before you complete the application. Failure to provide the required information may result in the application being considered incomplete. Attach additional sheets of paper, if necessary. The information will be used to determine if you qualify for licensure pursuant to California Business and Professions Code section 4053.2. An applicant who fails to complete all the application requirements within 60 days after being notified by the board of deficiencies, may be deemed to have abandoned the application and may be required to file a new application, fee, and meet all the requirements which are in effect at the time of reapplication.

Military Expedite

☐ **MILITARY** (Are you serving in the United States military?)
☐ **VETERAN** (Have you ever served in the United States military?)
☐ **ACTIVE DUTY MILITARY-Spouse or Partner**

Applicant Information - Please Type or Print

Full Legal Name: Last Name: First Name: Middle Name:

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

*Official Mailing/Public Street Address of Record (Street Address, PO Box #, etc.):

City: State: Zip Code:

Residence Street Address (if different from above):

City: State: Zip Code:

Home#: ( ) Cell#: ( ) Work#: ( )

Email Address: Driver's License #: State:

**US Social Security # or ITIN: Date of Birth (Month/Day/Year):

Mandatory Education (check one box)

Please indicate how you satisfy the education requirement in Business and Professions Code section 4053.2(b)(1).

☐ High school graduate or foreign equivalent.
Attach an official embossed transcript or notarized copy of your high school transcript, or certificate of proficiency, or foreign secondary school diploma along with a certified translation of the diploma.

☐ Completed a general education development certificate equivalent.
Attach an official transcript of your test results or certificate of proficiency.

TAPE A COLOR PASSPORT STYLE PHOTOGRAPH (2"X2") TAKEN WITHIN 60 DAYS OF THE FILING OF THIS APPLICATION
NO POLAROID OR SCANNED IMAGES
PHOTO MUST BE ON PHOTO QUALITY PAPER

Designated Representative-Reverse Distributor Qualifying Method

Please indicate how you qualify for a Designated Representative-Reverse Distributor license pursuant Business and Professions Code section 4053.2.

Experience

☐ I have a minimum of one year of paid work experience. Attach form 17A-E7.

OR

☐ I meet the prerequisites to take the examination required for licensure as a pharmacist. Attach documentation of your examination eligibility.

AND

Training

☐ I have completed the required training program. Attach form 17A-E8.

License Information: List all state(s), including California, where you hold or have held a license as a designated representative, intern pharmacist, pharmacist, pharmacy technician, and/or any other healthcare professional.

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

Enf. 1st Check	☐	FP Cards Fee /Live Scan	☐	License no.		Receipt #	
Photo	☐	FP Cards Sent		Date issued		Amount	
HS Doc	☐	DOJ Clear Date:		By:		Date Cashiered	
Exp. Affidavit	☐	FBI Clear Date:					
Training Affidavit	☐	Enf 2nd Check	☐				

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

Ownership Information - For any affirmative answer, 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. 1. 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?	1. Yes ☐ No☐
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. 2. 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?	2. Yes ☐ No☐
3. 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?	3. Yes ☐ No☐
4. 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?	4. Yes ☐ No☐
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. **For any affirmative answer, attach a statement of explanation.** 5. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice safely?	5. Yes ☐ No☐
6. Have you ever been diagnosed with a physical condition that may impair your ability to practice safely?	6. Yes ☐ No☐
7. Do you have any other condition that may in any way impair or limit your ability to practice safely?	7. Yes ☐ No☐
8. 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?	8. Yes ☐ No☐
9. If you answered "Yes" to questions 10 through 13 above, have you ever received treatment or participated in any program that improves your ability to practice safely?	9. Yes ☐ No☐ N/A ☐

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.

10. 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? 10. Yes ☐ No☐

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.

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

11. Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict? 11. Yes ☐ No☐

Arrest Date	Violation(s)	Case #	Court of Jurisdiction (Full Name and Address)

APPLICANT AFFIDAVIT

You must 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.

Collection and Use of Personal Information. The California State Board of Pharmacy of the Department of Consumer Affairs collects the personal information requested on this form pursuant to Business and Professions Code sections 30 and 4000 and following and California Code of Regulations title 16, division 17. The California State Board of Pharmacy uses this information principally to identify and evaluate applicants for licensure, issue, and renew licenses, and enforce licensing standards set by law and regulation.

Access to Personal Information. You may review the records maintained by the California State Board of Pharmacy that contain your personal information, as permitted by the Information Practices Act. The official responsible for maintaining records is the Executive Officer at the board's address listed on the application. Each individual has the right to review the files or records maintained by the board, unless confidential and exempt by law.

Possible Disclosure of Personal Information. We make every effort to protect the personal information you provide us. The information you provide, however, may be disclosed under the following circumstances:

- In response to a Public Records Act request (Government Code section 6250 and following), as allowed by the Information Practices Act (Civil Code section 1798 and following);
- To another government agency as required or permitted by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

***Address of Record:** 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 and following) and the Public Records Act (Government Code section 6250 and following) and will be available on the Internet. This is where the board will mail all official correspondence. 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 not your residence address, you must also provide your residence address to the board, in which case your residence will not be available to the public.

****Disclosure of your U.S. social security number or Individual Taxpayer Identification Number (ITIN) is mandatory.** Section 30 of the Business and Professions Code, section 17520 of the Family Code, 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, which 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.

MANDATORY REPORTER

Under California law, each person licensed by the California State Board of Pharmacy is a “mandated reporter” for both child and elder abuse or neglect laws. 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 the laws above 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, refer to Penal Code section 11164 and Welfare and Institutions Code section 15630 and following sections.

APPLICANT AFFIDAVIT

(must be signed and dated by the applicant)

I, _____ , hereby attest to the fact that I am the applicant
(Print Full Legal Name)

whose signature appears below. 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 understand that my application may be denied, or any license disciplined, for fraud or misrepresentation.

_____ _____
Original Signature of Applicant (please sign and date within 60 days of board receipt of the application) Date

AUTHORIZATION TO RELEASE APPLICANT INFORMATION

(Optional)

The board will only disclose information pertaining to an application directly to the applicant. In order for the board to discuss the status of this application with another individual, the applicant must authorize the board in writing to discuss the application status with his or her authorized representative.

Giving consent for the board to disclose application information will authorize the board to disclose all personal 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 denied status, and any criminal conviction information the board may have on record for your application.

By completing this form, you will give the board consent to communicate to the individual or business listed below about the status of your application.

I, _____, hereby give
(Applicant's Full Name as Indicated on the Designated Representative-Reverse Distributor Application)

consent to the California State Board of Pharmacy to disclose information about my designated representative-reverse distributor application information as specified above to the following individual:

Name:				Telephone:
Mailing Address:	Street	City	State	Zip
E-mail Address:				

APPLICANT CONSENT

(must be signed and dated by the applicant)

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

_____ _____

Original Signature of Applicant Date

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DESIGNATED REPRESENTATIVE-REVERSE DISTRIBUTOR EXPERIENCE AFFIDAVIT

To be completed by the person having direct knowledge of the applicant's PAID work experience.

The individual applying for licensure as a designated representative-reverse distributor in California pursuant to Business and Professions Code section 4053.2 must have a minimum of one year paid work experience in one of the following:

1. In a licensed pharmacy, wholesaler, or third-party logistics provider, in the past three years, performing duties related to the distribution, dispensing, or destruction of dangerous drugs or dangerous devices.

OR

2. In the destruction of outdated or nonsaleable dangerous drugs or dangerous devices pharmaceutical waste. *Dangerous drugs and dangerous devices are defined in Business and Professions Code section 4022*.

A. THIS SECTION MUST BE COMPLETED BY APPLICANT (Please print clearly or type)

Name of Applicant	Last	First	Middle	Former Name(s)

Residence Address	Number and Street	City	State	Zip Code

B. WORK EXPERIENCE: This section must be completed by the person having direct knowledge of the applicant's PAID work experience. The applicant may not verify his/her own experience. Please mark the box that identifies where the paid work experience was obtained.

The paid work experience was: (check the appropriate box)

- ☐ in a licensed pharmacy, wholesaler, or third-party logistics provider. *Attach an official license verification if the facility is not licensed in California.*
- ☐ in the destruction of outdated or nonsaleable dangerous drugs or dangerous devices pharmaceutical waste.

Name of Applicant	Last	First	Middle

Dates of PAID Work Experience DO NOT enter "current", "present" or "still employed" (enter exact dates of paid work experience only)		
From: (mm/dd/yyyy)	To: (mm/dd/yyyy)	Number of years

WORK EXPERIENCE LOCATION

Name of Business/Employer		License Type and Number (pharmacy, wholesaler, or third-party logistics provider)		
Business/Employer Address	**Number and Street**	**City**	**State**	**Zip Code**

I certify under penalty of perjury under the laws of the State of California that all statements given under section "B" of this form herein are true, and that to the best of my knowledge the experience gained by this applicant meets the requirements as required by law.

Original Signature of person having direct knowledge of applicant's paid work experience — Date

Printed name and title of person having direct knowledge of applicant's paid work experience — Telephone Number

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BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
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DESIGNATED REPRESENTATIVE-REVERSE DISTRIBUTOR TRAINING AFFIDAVIT

To be completed by the person having direct knowledge of applicant's training.

The individual applying for a designated representative-reverse distributor license in California has completed training approved by the board, at a minimum:

A. Knowledge and understanding of California law and federal law relating the distribution of dangerous drugs and dangerous devices.
B. Knowledge and understanding of California law and federal law relating the distribution of controlled substances.
C. Knowledge and understanding of California law and federal law relating to the removal and destruction of dangerous drugs, dangerous devices, and pharmaceutical waste.
D. Knowledge and understanding of United States Pharmacopoeia or federal Food and Drug Administration standards relating to the safe storage, handling, and transport of dangerous drugs and dangerous devices.

A. TO BE COMPLETED BY APPLICANT: (Please print clearly or type)

Name of Applicant	Last	First	Middle

Residence Address	Number and Street	City	State	Zip Code

B. TRAINING – To be completed by the person having direct knowledge of the applicant's training. The applicant may not verify his/her own training.

DATES TRAINING PROVIDED:

Name of Applicant	Last	First	Middle

Dates of Training DO NOT enter "current" or "present" (enter exact dates only)		
From: (mm/dd/yyyy)	To: (mm/dd/yyyy)	Number of hours/years

THIS TRAINING WAS PROVIDED BY:

Name of company, school or individual providing the training				
Address	City	State	Zip Code	Telephone Number

I certify under penalty of perjury under the laws of the State of California that all statements given under section "B" of this form herein are true, and that to the best of my knowledge the training gained by this applicant meets the requirements as required by law.

Original Signature of person having direct knowledge of applicant's training — Date

Printed name and title of person having direct knowledge of applicant's training — Telephone Number

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GOVERNOR EDMUND G. BROWN JR.

VERIFICATION OF LICENSE IN ANOTHER STATE

This form must be completed by the licensing agency in each state you hold or held a pharmacist, intern pharmacist, pharmacy technician, designated representative, designated representative-3PL license and or another healthcare professional license even if the license is no longer current or active. Please return the state-verified form with your application for each license type. Photocopies or faxes will not be accepted.

Intern hours and licensure earned in another state may be certified by the licensing agency in each state you earned your intern hours or license on this form.

A. TO BE COMPLETED BY APPLICANT (Please print or type)

Name of Applicant:				Telephone Number:
Residence Address:	Number and Street	City	State	Zip Code
Type of License:	License Number:	Date Issued:	Expiration Date:	

The person listed above has applied for a pharmacist license in California. Before further consideration is given to this application, the California State Board of Pharmacy would appreciate your assistance in completing the information requested below. Upon completion of this form, please return it to the applicant for submission with the application.

B. TO BE COMPLETED BY THE STATE LICENSING BOARD OR AGENCY VERIFYING LICENSURE

Licensee's Full Name:				Licensure Verification Provided by the State of:
Type of License Issued:	License Number:	Date License Issued :	Expiration Date:	Intern Hours Earned in this State under this Intern License:

License Status (please check one box):

Active ☐ Inactive ☐ Other ☐ If other, please explain: _____

Has this agency taken any disciplinary action against this license? Yes ☐ No ☐

If disciplinary action has been taken against this licensee, please directly provide this office with the accusation/proposed charges and decision/final order regarding the action.

I hereby certify the information listed in Section "B" above is true and correct.

Board Seal

_____
Printed Name

_____
Signature

_____
Title of Authorized Official

_____
Date

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

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

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

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

Applicant Information:

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

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

Employer: This information is not required.

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

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (DOJ processing fee of $32, FBI processing fee of $17, and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about $5 to $20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs. The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

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

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

DEPARTMENT OF JUSTICE

REQUEST FOR LIVE SCAN SERVICE

Print Form Reset Form

Applicant Submission

A0071
ORI (Code assigned by DOJ)

License/Cert/Permit
Authorized Applicant Type

Pharmacy Wholesaler - Section 4305.5
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Board of Pharmacy
Agency Authorized to Receive Criminal Record Information

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

1625 N. Market Blvd, Suite N219
Street Address or P.O. Box

Licensing
Contact Name (mandatory for all school submissions)

Sacramento
City

CA
State

95834
ZIP Code

(916) 574-7900
Contact Telephone Number

Applicant Information: **Live Scan Operator – The Board of Pharmacy requires you to enter the applicant's SSN.**

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 - **MANDATORY**

Misc. Number
(Other Identification Number)

Home Address Street Address or P.O. Box

City State ZIP Code

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

Level of Service: ☒ DOJ ☒ FBI

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

Original ATI Number

Employer (Additional response for agencies specified by statute):

N/A
Employer Name

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

N/A
Street Address or P.O. Box

N/A
City

State

ZIP Code

N/A
Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed

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