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 APPLICATION INSTRUCTIONS

A person applying for a designated representative license must demonstrate he/she meets the requirements for licensure pursuant to Business and Professions Code section 4053.

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 to 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 LICENSE** (form 17A-E): Complete the entire application. *A licensed pharmacist is not required to be licensed as a designated representative 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 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 license 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 **ONE** of the following (A or B).

A. Designated Representative Experience Affidavit (form 17A-E2): Submit this form documenting completion of a minimum of one year of paid work experience in the past three years, related to the distribution or dispensing of dangerous drugs or dangerous devices in a licensed pharmacy, drug wholesaler, drug distributor, or drug manufacturer. 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-E2) 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.

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. This may include your examination eligibility letter that identifies the date you were deemed eligible to sit for the examination.

☐ **REQUIRED TRAINING:** Designated Representative Training Affidavit (form 17A-E3). Submit this form documenting that you have completed a training program pursuant to Business and Professions Code section 4053. 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, 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 LICENSE APPLICATION

All information requested in this application is mandatory. Failure to provide any information will result in the application being considered incomplete. The information will be used to determine if you qualify for licensure pursuant to California Business and Professions Code section 4053. An applicant for a designated representative license, 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.

Read the application instructions before you complete the application. All questions on this application must be answered and signed by the applicant. If not applicable, indicate N/A. Attach additional sheets of paper, if necessary.

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 Lic. No: State:

**Social Security # or Individual Tax ID #: Date of Birth (Month/Day/Year):

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

Mandatory Education (check one box)

Please indicate how you satisfy the mandatory high school education requirement in Business and Professions Code section 4053(b)(1).

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

OR

☐ Completed a General Education Development equivalent certificate. *Attach an official transcript of your test results or certificate of proficiency.*

Designated Representative Qualifying Method

Please indicate how you qualify for a Designated Representative license pursuant Business and Professions Code section 4053.

Experience

☐ I have a minimum of one year of paid work experience, in the past three years. Attached is form 17A-E2.

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. Attached is form 17A-E3.

License Information: List all state(s), including California, where you hold or have held a license as a designated representative/3PL, intern pharmacist and/or pharmacy technician, and/or any other healthcare professional license. Attach additional sheets if necessary.

State	Registration 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	☐				

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

1. Do you have a mental illness or physical illness that in any way impairs or limits your ability to practice your profession with reasonable skill and safety without exposing others to significant health or safety risks? **If "yes," attach a statement of explanation. If "no," proceed to #2.** Are the limitations caused by your mental illness or physical illness reduced or improved because you receive ongoing treatment or participate in a monitoring program? Yes ☐ No ☐ **If "yes," 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 mental illness or physical illness to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for license.	Yes ☐ No ☐
2. Do you currently engage or have previously engaged in the illegal use of controlled substances? If "yes," are you currently participating in a supervised substance abuse 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? Yes ☐ No ☐ **Attach a statement of explanation.**	Yes ☐ No ☐
3. Do you currently participant in a substance abuse program or have previously participated in a substance abuse program in the past five years? If "yes," are you currently participating in a supervised substance abuse program or professional assistance program which monitors you to ensure you are maintaining sobriety? Yes ☐ No ☐ **Attach a statement of explanation.**	Yes ☐ No ☐
4. Has disciplinary action ever been taken against your designated representative, pharmacist, intern pharmacist and/or pharmacy technician license 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 ☐
5. Have you ever had an application for a designated representative, pharmacist, intern pharmacist and/or pharmacy technician license 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 ☐
6. Have you ever had a pharmacy license, or any professional or vocational license or registration, denied, suspended, revoked, placed on probation or had other disciplinary action taken by this or any other government authority in California or any other state? If "yes," provide the name of company, type of permit, type of action, year of action and state. _____	Yes ☐ No ☐
7. 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, medical device retailer 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 ☐
8. Have you ever been convicted of, or pleaded guilty or nolo contender/no contest to, any crime, in any state, the United States or its territories, a military court, or any foreign country? Include any felony or misdemeanor offense, and any infraction involving drugs or alcohol with a fine of $500 or more. You must disclose a conviction even if it was: (1) later dismissed or expunged pursuant to Penal Code section 1203.4 et seq., 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 et seq., or an equivalent post-conviction drug treatment diversion dismissal provision from a non-California jurisdiction. Failure to answer truthfully and completely may result in the denial of your application. 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 more than two years old on the date you submit your application for violations of California Health and Safety Code section 11357, subdivisions (b), (c), (d), or (e), or California Health and Safety Code section 11360, subdivision (b); and (4) infractions or traffic violations with a fine of less than $500 that do not involve drugs or alcohol. You may wish to provide the following information in order to assist in the processing of your application: descriptive explanation of the circumstances surrounding the conviction (i.e. dates and location of incident and all circumstances surrounding the incident). If documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is required. **Failure to disclose a disciplinary action or conviction may result in the license being denied or revoked for falsifying the application. Attach additional sheets if necessary.**	Yes ☐ No ☐

Arrest Date	Conviction 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 do so will result in this application being deemed incomplete. Falsification of the information on this application may constitute ground for denial or revocation of the license.

All items of information requested in this application are mandatory. Failure to provide any of the requested information may result in the application being rejected as incomplete.

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 as authorized by Business and Professions Code Sections 4000 and Title 16 California Code of Regulations, 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.

Mandatory Submission. Submission of the requested information is mandatory. The California State Board of Pharmacy cannot consider your application for licensure or renewal unless you provide all of the requested information.

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 Civil Code Section 1798.40.

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 in 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.

*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. This is where the board will mail all 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 account 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: Effective July 1, 2012, 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 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 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 Section 11164 and Welfare and Institutions Code Section 15630, and subsequent sections.

APPLICANT AFFIDAVIT

(must be signed and dated by the applicant)

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

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 (signed and dated within 60 days of filing 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.

As the applicant, I hereby give the board consent to communicate to the individual or business listed below.

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

consent to the California State Board of Pharmacy to disclose information about my designated representative 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, upon licensure, whichever comes first. (Date)

_____ _____

Original Signature of Applicant Date

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DESIGNATED REPRESENTATIVE EXPERIENCE AFFIDAVIT

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

The individual applying for licensure as a designated representative in California must have a minimum of one year of paid work experience in a licensed pharmacy, drug wholesaler, drug distributor, or drug manufacturer, in the past three years, related to the distribution or dispensing of dangerous drugs or dangerous devices pursuant to California Business and Professions Code section 4053. Dangerous drugs and 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
Home/Cell Telephone Number		**Work Telephone Number**		

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.

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 Number (pharmacy, wholesaler, drug distributor, or manufacturer license number)		
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. I further certify that the license listed above in section "B" of this form was not revoked, suspended, or on probation in the state during the time the work experience was gained.

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

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

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DESIGNATED REPRESENTATIVE TRAINING AFFIDAVIT

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

The individual applying for a designated representative license in California has completed training required by Section 4053(3) of the California Business and Professions Code that addressed, at a minimum:

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

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

Name of Applicant Last	First	Middle	
Residence Address Number and Street	City	State	Zip Code
Home/Cell Telephone Number	Work Telephone Number		

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 of person having direct knowledge of applicant's training Title Telephone Number

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

NOTE TO LICENSEE and LIVE SCAN OPERATOR: The name, date of birth and US Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN) 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 the name, date of birth or SSN or ITIN is not entered at the time of Live Scan transmission, the licensee 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 your type of license. Please have the Live Scan operator enter in in the Type of License listed on the Live Scan Form.

Applicant Information:

- **Name:** Enter your last name, first name and middle name. 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:** California 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, enter this number in the SSN field.
- **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 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.

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 $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.

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