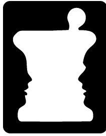


California State Board of Pharmacy
1625 N. Market Blvd, N219, Sacramento, CA 95834
Phone: (916) 574-7900
Fax: (916) 574-8618
www.pharmacy.ca.gov

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

REQUIREMENTS FOR FILING AN APPLICATION FOR A NONRESIDENT OUTSOURCING FACILITY LICENSE

(Business & Professions Code (BPC) Sections 4034, 4129 & 4129.1)

Effective January 1, 2017, an entity must have a license issued by the board prior to conducting business within or into California as an outsourcing facility.

Complete this application if the outsourcing facility meets the following criteria:

1. The facility that is located within the US, but outside of California, and is engaged in compounding of sterile and nonsterile drugs; **AND**
2. The facility is registered with the federal Food and Drug Administration (FDA) under Section 503B of the federal Food Drug and Cosmetic Act; AND
3. The facility is doing business into California.

Note: A facility licensed with the board as a sterile compounding pharmacy may not be concurrently licensed with the board as an outsourcing facility at the same location.

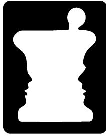
Application Requirements - Please complete and/or submit the following:

1. Application Form (17A-91).
2. Fee of $2,380 made payable to "Board of Pharmacy."
3. Copies of all federal and state regulatory agency inspection reports, as well as accreditation reports, and certification reports of facilities or equipment of the outsourcing facility's premises conducted in the prior 12 months.
4. Current copy of the outsourcing facility's policies and procedures for sterile compounding and nonsterile compounding. The policies and procedures may be submitted electronically to the following e-mail address: compounding.pharmacy@dca.ca.gov. Please include the FDA Registration Number in the e-mail.
5. The most recent list of all sterile drugs and nonsterile drugs compounded by the facility as reported to the FDA in the last 12 months.
6. Ownership information - Each officer/owner/manager must submit the following:
    a. Certification of Personnel (form 17A - 11)
    b. Individual Personal Affidavit (form 17A - 27)
    c. Copy of Request for Live Scan Service Form verifying that fingerprints have been scanned and all applicable fees have been paid. (For officers/owners/manager applicants outside of California, please contact the board for fingerprint cards. Please note that fingerprint card will require an additional $49 per set of cards.)

Application Process

1. Upon receipt of the application and fees, the board will review the application and advise the designated person if any additional information is required.

2. Once the application is deemed complete, the board will conduct an inspection. Prior to the inspection the board will send a letter advising the applicant of the estimated costs associated with the inspection. The board will require payment of the estimated costs in advance of the inspection.
3. After compliance is confirmed via the inspection process, assuming there are not grounds for denial, the board will issue a license for a period of up to one year. Thereafter renewals will be done annually.



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BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
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APPLICATION FOR NONRESIDENT OUTSOURCING FACILITY LICENSE

Please print or type **PLEASE COMPLETE ALL BLANKS; IF NOT APPLICABLE, ENTER N/A**

Name of Outsourcing Facility:				FDA Registration Number:
Telephone Number:	Alternative Telephone Number: (if applicable)			
Address of Outsourcing Facility: Street and Number	City	State	Zip Code	

Indicate whether this application is for:

☐ New Outsourcing Facility License ☐ Change of Location of a Licensed Outsourcing Facility ☐ Change of Ownership of a Licensed Outsourcing Facility

If this is a **change of ownership** or **change of location**, indicate previous name, address and license number of the Outsourcing Facility.

Name:	Address:	License Number:

Please indicate type of ownership:

☐ Individual ☐ Partnership ☐ Corporation
☐ Limited Liability Company ☐ Not-for-Profit Corporation ☐ Government Owned
☐ Trust ☐ Unincorporated Association

Does your facility compound from bulk drug substances? Yes No
If yes please indicate the type(s) of compounding performed.
Sterile Nonsterile Both Sterile and Nonsterile

I certify under penalty of perjury the above is true and correct, that all attachments submitted with this application are true and correct, and that the policies and procedures for the compounding of all sterile products and nonsterile products are done in compliance with federal current good manufacturing practices applicable to outsourcing facilities.

____________________ ____________________ __________
Signature of Person Authorized Name (Please Print) Date

FOR OFFICE USE ONLY		
STAFF REVIEW		CASHIER LOG
☐ ________ ☐ ________ ☐ ________ ☐ ________ Referred for inspection: ________ Inspection Completed: ________	Approved ________ Denied Date ________	Cashier # Date Amount of fee

(17A-91) rev 11.2016

Ownership Information

If a Sole Ownership:				
Name of Sole Owner		Social Security Number or ITIN		Telephone Number
Address	Number and Street	City	State	Zip Code

If a Partnership: (attach additional sheet if needed)				
Name of Partner		FEIN Number		Telephone Number
Address	Number and Street	City	State	Zip Code
Name of Partner		FEIN Number		Telephone Number
Address	Number and Street	City	State	Zip Code

If Government Owned:				
Name of Government Entity		Primary Government Contact Name		Telephone Number
Address	Number and Street	City	State	Zip Code

Please indicate alternate type of ownership if applicable:

☐ **Corporation** ☐ **Limited Liability Company** ☐ **Not-for-Profit Corporation** ☐ **Unincorporated Association:**
(attach additional sheet if needed)

Name of Corporation, Limited Liability Company, Not-for-Profit Corporation or Unincorporated Association				Telephone Number
Address	Number and Street	City	State	Zip Code

Print below the name, title, address and license number (if any) of all the outsourcing facility's owners. This includes the individual owners, all partners, stockholders or members. Please indicate if the number of owners exceeds five in total. If so please list only the five largest interests in the outsourcing facility. Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, nurse, physician's assistant, podiatrist, dentist, veterinarian, etc., and license number. Attach additional sheets if necessary.

% of Ownership	Name	Residence Address	Usual Occupation or Professional Qualifications	Licensed as and License Number

Print below the name, title, address and license number (if any) of all the outsourcing facility's officers. Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, nurse, physician's assistant, podiatrist, dentist, veterinarian, etc., and license number. Non-profit organizations must list the names and titles of persons holding corporate positions. Attach additional sheets if necessary.

Title	Name	Residence Address	Usual Occupation or Professional Qualifications	Licensed as and License Number

If a Trust: (attach additional sheet if needed)

Name of Trust	Name of Trustor (if applicable)	Telephone Number

Address	Number and Street	City	State	Zip Code

Name of Trustee	Usual Occupation or Professional Qualifications	Telephone Number

Address	Number and Street	City	State	Zip Code

Name of Person with Control Over the License (if applicable)	Usual Occupation or Professional Qualifications	Telephone Number

Address	Number and Street	City	State	Zip Code

Name of Person with Control Over the License (if applicable	Usual Occupation or Professional Qualifications	Telephone Number

Address	Number and Street	City	State	Zip Code

Disclosure of your social security number or individual taxpayer identification number (ITIN) (or federal employer identification number ("FEIN") if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number or ITIN. Your social security number, ITIN or FEIN will be used exclusively for tax enforcement purposes or compliance with any judgment or order for family support in accordance with section 17520 of the Family Code. If you fail to disclose your social security number, ITIN or your FEIN, your application for initial or renewal license 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 individual taxpayer information with the board. You are obligated to pay your state tax obligation. This application may be denied or your license may be suspended if the state tax obligation is not paid.

Federal Employer Identification Number (FEIN)

PLEASE READ CAREFULLY

Your application must be approved by the California State Board of Pharmacy before an Outsourcing Facility License will be issued.

If changes are made during the application process, you may need to submit a new application with the appropriate fees. **Any application not completed within 60 days after you have been notified by the board of deficiencies in your file, may be deemed to have been abandoned, and you may be required to file a new application and meet all the requirements which are in effect at the time of application. Fees applied to this application are not transferable and are not refundable.**

Any material misrepresentation in the answer of any question is grounds for denial or subsequent revocation of a license, and may be a violation of the Penal Code of California. 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.

The information will be used to determine qualifications for licensure under California Pharmacy Law. The officer responsible for information maintenance is the Executive Officer, (916) 574-7900, 1625 North Market Boulevard, Suite 219, 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 him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted from disclosure by the California Information Practices Act. (Civil Code §1798, et seq.)

Signature Block

By signing this application, I certify or affirm that, under penalty of perjury under the laws of the State of California, that: (1) I am a person authorized to act for and bind the applicant and I am at least 18 years of age; (2) no person other than the applicant [or applicants] has any direct or indirect interest in the applicant's [or applicants'] business to be conducted under the license for which this application is made; (3) all supplemental statements filed with this application are true, complete and accurate; (4) I have not been convicted of a felony and have not violated any of the provisions of this chapter; (5) I have read the foregoing application and know the contents thereof and each and every statement made therein is true; and (6) I understand that falsification of any information I this application may constitute grounds for denial or subsequent revocation of the license.

Signature of Person Authorized to Submit Application	Name (please print)	Title	Date
Mail correspondence to the following address. If correspondence should be mailed to the applicant address, please indicate "same as outsourcing facility.			
Name of contact person to clarify information provided on this application	Phone number	E-mail address	

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

CERTIFICATION OF PERSONNEL

INSTRUCTIONS: **Must be completed by each owner, director, officer, major shareholder and pharmacist-in-charge.** All blanks must be completed; if not applicable, enter N/A. Failure to furnish a complete explanation or any omissions **will delay** the processing of your application.

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

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

License Type	License Number	State	Expiration Date

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

Name	Relationship	License Type	License Number	State

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

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

6. Have you ever had a pharmacy permit, or any professional or vocational license or registration denied, suspended, revoked, placed on probation or other disciplinary action taken by this or any other governmental authority in this state or any other state? If "yes," please provide permit type, action, company name (if applicable), year of action and state. (Use additional sheets if necessary.)

☐ Yes ☐ No

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

7. Are you currently, or have you previously been, associated in business with any person, partnership, corporation, or other entity, or shared a financial or community property interest with any person whose pharmacy permit, or any professional or vocational license was denied, suspended, revoked, or placed on probation or other disciplinary action taken, by this or any other governmental authority in this state or any other state? If the answer is "yes," please list the company name, permit type, action, year of action and state. (Use additional sheets if necessary.)

☐ Yes ☐ No

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

8. Have you ever been in violation of any provisions of pharmacy law, in this or any other state? If "yes," please list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.)

☐ Yes ☐ No

Type of Violation	License Number	Type of Action	Year of Action	State

9. Have you ever been convicted of, or pled no contest to, a violation of any law of a foreign country, the United States, any state or local jurisdiction? You must include all misdemeanor and felony convictions, regardless of the age of the conviction, including those which have been set aside and/or dismissed under Penal Code section 1210.1 or 1203.4. (Traffic violations of $500 or less need not be reported.) If "yes," please attach an explanation which must include the type of violation, the date, circumstances and location, and the complete penalty received.

☐ Yes ☐ No

10. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety without exposing others to significant health and safety risks?

☐ Yes ☐ No

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

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

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

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

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

____

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

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

(a) any non-pharmacist owner who commits any act which would subvert or tends to subvert the efforts of the pharmacist-in-charge to comply with the laws governing the operation of the pharmacy is guilty of a misdemeanor;

(b) you may not order a pharmacist to perform any act which is prohibited by law;

(c) any violation of the Federal Food, Drug & Cosmetic Act, the Federal Controlled Substance Act or any law or regulation relating to the practice of pharmacy in the State of California is grounds for suspension or revocation of the permit for which you are applying;

(d) committing any act prohibited by law, or neglecting to perform any duty required by law, could result in proceedings against the personal license of a pharmacist or could result in an action against your permit.

(e) you are not permitted to assist in any phase of compounding or dispensing of prescriptions, or to perform any of the duties which are required by law or regulation to be done by a pharmacist;

(f) only a pharmacist may possess the key to the pharmacy or to the permanent barrier separating the pharmacy;

(g) you may enter the pharmacy for the purpose of performing certain specified duties only when the pharmacist is present; and the pharmacist is responsible for any non-registered person allowed to enter the pharmacy. (This does not apply to hospital pharmacies or limited permits under Business and Professions Code section 4117, or Title 16, California Code of Regulations section 1714);

(h) dangerous drugs and/or devices as defined in Business and Professions Code sections 4022 and 4023 may only be sold on prescription or to persons who are licensed to handle, sell and possess such drugs.

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

NOTICE: Effective July 1, 2012, the State Board of Equalization and the Franchise Tax Board may share individual taxpayer information with the board. You are obligated to pay your state tax obligation. This application may be denied or your license may be suspended if the state tax obligation is not paid.

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

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

____ ________________________

Signature Date

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

INDIVIDUAL PERSONAL AFFIDAVIT

Please print or type **All blanks must be completed; if not applicable enter N/A**

Full name: Last	First	Middle
Previous name(s) – include maiden name, also known as (AKA's), "aliases":		Attach a photograph taken within 60 days of the filing of this affidavit **NO POLAROID**
Residence address: Number and Street City State Zip Code		
Date of birth (month/day/year)	Place of birth (city, state, country)	
Driver's license no & state issued in	*Social Security number	
Home telephone:	Current work telephone:	
Name of applicant premises:	Number and Street City State Zip Code	
Address of applicant premises:		
Premises telephone:		

I am (Check all that apply)

- ☐ Sole owner
- ☐ Officer
- ☐ General partner
- ☐ Financier/lender
- Other - Specify: ____________________
- ☐ Partner
- ☐ Director
- ☐ Stockholder ______%
- ☐ Member (LLC only)

Spouse's name (Include alias or maiden) Last	First	Middle
Spouse's social security number	Spouse's Date of Birth	Will your spouse work in any capacity under the permit? Yes ☐ No ☐

Do you have, or have you had, any direct or indirect beneficial interest in any other premises licensed by any board of pharmacy? Include sites licensed in states other than California.

Yes ☐ No ☐

If yes, list current direct or indirect beneficial interests (use an additional sheet if necessary).

Name	Address	Permit Number
Name	Address	Permit Number
Name	Address	Permit Number

If yes, list past direct or indirect beneficial interests during the last five years (use additional sheet if necessary):

Name	Address	Permit Number
Name	Address	Permit Number

Have you -- as an owner, shareholder, officer, member, director or partner -- been involved with a pharmacy, drug wholesaler, medical device retailer, hypodermic permit or out-of-state distributor whose license has been disciplined or an offer in compromise accepted or rejected by a state board of pharmacy or federal regulatory agency? Have you as an individual held a pharmacist license, pharmacy technician registration or exemption certificate that has been disciplined or an offer in compromise accepted or rejected by a state board of pharmacy or federal regulatory agency? Also describe if any of the above actions have occurred with your spouse or palimony partner, or an associate with whom you have shared any ownership interest. Describe the event, regulatory agency involved and date for each incident. (If yes, explain. Use additional sheets if necessary)

Yes ☐ No ☐

Have you as an individual ever been issued any professional or vocational license such as a medical doctor, attorney, dentist, contractor, etc. that has been disciplined by a state regulatory board? (If yes, explain.)

Yes ☐ No ☐

Current and past employment for at least the past five years. (Use additional sheets if necessary).

From (mo/yr)	To (mo/yr)	Type of Work	Firm name and city

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 authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of financial records consisting of signature cards, checking and savings accounts, note and loan documents, deposit and withdrawal records, and escrow documents of my financial institution(s) or any financial records established in connection with this business. This authorization to examine records at any financial institution may be at any time. I also authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of any business records or documents established in connection with this business including, but not limited to those on file with my bookkeeper.

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

Applicant Signature Title Date

Place Attest (Notary Public

Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code 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, or for verification of 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, your application for initial or renewal license will not be processed AND you will 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 individual taxpayer information with the board. You are obligated to pay your state tax obligation. This application may be denied or your license may be suspended if the state tax obligation is not paid.

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 or individual taxpayer identification 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 required information indicated below is not entered at the time of Live Scan transmission, the applicant may be required to have a new Live Scan transmission completed.

REQUIRED INFORMATION

- **Type of License/Certification/Permit OR Working Title:** It is important that you print out the Live Scan form that goes with your application, as this information is already entered on the form for you. It is important that the Live Scan operator types in this information exactly into their system or at least the numeric section.
- **Name:** Enter your name as it appears on your U.S. government photo identification. If you change your name, 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 (Mandatory):** Enter your US Social Security Number or individual taxpayer identification number
- **Misc. Number:** Other identification number
- **Home Address:** Your residence address
- **Level of Service:** 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.

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.php 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. Please print three copies of the Request for Live Scan Service form. 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

Applicant Submission

ORI (Code assigned by DOJ) ____________________

Authorized Applicant Type ____________________

Nonres Outsrc Fac 4201 BP

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

Contributing Agency Information:

Agency Authorized to Receive Criminal Record Information ____________________

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

Street Address or P.O. Box ____________________

Contact Name (mandatory for all school submissions) ____________________

City ______ State ______ ZIP Code ______

Contact Telephone Number ____________________

Applicant Information: **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: ____________________ OCA Number (Agency Identifying Number)

Level of Service: ☐ DOJ ☐ FBI

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

Original ATI Number ____________________

Employer (Additional response for agencies specified by statute):

Employer Name ____________________

Mail Code (five digit code assigned by DOJ ____________________

Street Address or P.O. Box ____________________

City ______ State ______ ZIP Code ______

Telephone Number (optional) ____________________

Live Scan Transaction Completed By:

Name of Operator ____________________

Date ____________________

Transmitting Agency ______ LSID ______ ATI Number ______ Amount Collected/Billed ______

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