



INSTRUCTIONS FOR FILING AN APPLICATION TO OBTAIN A VETERINARY FOOD-ANIMAL DRUG RETAILER LICENSE

A veterinary food-animal drug retailer (vet retailer) is an area, place, or premises, other than a pharmacy, that holds a valid license from the Board of Pharmacy of the State of California as a wholesaler and, in and from which veterinary drugs for food-producing animals are dispensed pursuant to a prescription from a licensed veterinarian.

For each site licensed by the board, there must be:

1. A wholesale drug license for the premises that is specific to the designated address.
2. A vet retailer license that is specific to the same address as the wholesaler.
3. A California-licensed pharmacist or a person who is specially authorized by the board as an designated representative, and who is designated as an designated representative-in charge of the vet retailer site. Designated representatives for vet retailers must have specific training in addition to that which is required for wholesale designated representatives.
4. At least one California-licensed pharmacist or vet retailer designated representative present during all hours of operation. Note; more than one pharmacist or vet retailer designated representative may be employed at the site.

There can be multiple vet retailer designated representative working for a single vet retailer location, however each location must designate a designated representative -in-charge. If a designated representative -in-charge leaves the employment of the vet retailer, a new one must be designated within 30 days in writing on a form furnished by the board.

Licenses cannot be transferred to a new location or to new owners. The board must approve any new location or new owner **BEFORE** the change occurs (allow 60 days). Licenses are issued for one year, and must be renewed before expiration or else the vet retailer cannot operate until the license is renewed. Failure to renew the license within 60 days from the expiration date may result in the license being cancelled. If operations are to be resumed, a new application (with all documents) must be submitted and approved prior to business resumption.

IMPORTANT

Please follow these instructions completely. Failure to submit the necessary items will delay the processing of your application. Any forms that have been previously submitted with another application will not be pulled from the file. You must complete and submit all of the requested information. If the number of forms provided is not sufficient, please make photocopies. You will be notified of any deficiencies in your application. Please allow approximately 60 days from the time your application packet is complete before calling the Board of Pharmacy.

SUMMARY OF CHECKLIST

Section A	Requirements for all applicants
Section B	Forms required for an applicant who is filing as an individual owner
Section C	Forms required for an applicant whose ownership is a partnership
Section D	Forms required for an applicant who is filing as a corporation

CHECKLIST FOR FILING A VETERINARY FOOD-ANIMAL DRUG RETAILER APPLICATION

Section A All Applicants

- 1. The application fee of \$405 **Note:** All veterinary food-animal drug retailer change of ownership applications will be considered for temporary permits. Whenever a change of ownership occurs, either a temporary permit will be pursued or operation must stop. In addition to the regular items required for this application, a \$250 temporary permit fee must also be submitted.
- 2. Completed application for Veterinary Food-Animal Drug Retailer license (17A-31)
- 3. Business Background Affidavit (17A-18)
- 4. Seller's Certification (17A-16) (If applicable)
This is only required for an application for a change of ownership and it must be submitted by the prospective owner(s).
- 5. Report of Designated Representative-in-Charge form (17A-3)
The designated representative must be licensed as a Veterinary Food-Animal Drug Retailer designated representative or a California licensed pharmacist.

Section B Individual Owner who is Not Incorporated ONLY

In addition to items listed in section A, an individual owner must submit:

- 1. Personal Background Affidavit (17A-37)
- 2. Copy of *Request for Live Scan Service Form* verifying that your fingerprints have been scanned and all applicable fees have been paid. Please refer to fingerprint instructions on page 6.

Section C Partnership ONLY

In addition to items listed in section A, the following must be submitted:

- 1. Each partner must submit:
 - Personal Background Affidavit (17A-37)

- Copy of *Request for Live Scan Service Form* verifying that fingerprints have been scanned and all applicable fees have been paid. Please refer to fingerprint instructions on page 6.

[] 2. Signed Partnership Agreement

Section D Corporation ONLY

In addition to items listed in section A, the following items must be submitted:

[] 1. Each owner, or top 5 corporate officers must submit:

- Personal Background Affidavit (17A-37)
- Copy of *Request for Live Scan Service Form* verifying that fingerprints have been scanned and all applicable fees have been paid. Please refer to fingerprint instructions on page 6.

[] 2. Articles of Incorporation **endorsed** by the Secretary of State.

Fingerprint Requirements

California Residents

The board will only accept Live Scan Service Forms from California residents.

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

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

Non California Residents

For every owner, partner, corporate officer, major shareholder or director who resides out of state, he or she must submit rolled fingerprints on cards provided by the board and include a separate fee of \$49 (\$32 California Department of Justice (DOJ) fee and \$17 FBI fingerprint processing fee). (Live Scan processing fees are paid directly at the Live Scan site.) You may contact the board to request fingerprint cards at (916) 574-7900. You may also request cards on our website at www.pharmacy.ca.gov.

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

The board will only accept fingerprint cards from residents outside of California.



California State Board of Pharmacy
 1625 N. Market Blvd, Suite N219, Sacramento, CA 95834
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 www.pharmacy.ca.gov

STATE AND CONSUMERS AFFAIRS AGENCY
 DEPARTMENT OF CONSUMER AFFAIRS
 GOVERNOR EDMUND G. BROWN JR.

Veterinary Food-Animal Drug Retailer Application

(Referred to as "Veterinary Retailer")

Please print or type

ALL BLANKS MUST BE COMPLETED; IF NOT APPLICABLE, ENTER N/A

Name of Veterinary Retailer:		Veterinary Retailer telephone no: ()		
Address of Veterinary Retailer:	Number and Street	City	State	Zip Code
Indicate whether this application is for:				
<input type="checkbox"/> Change of location of an existing veterinary retailer		<input type="checkbox"/> Change of ownership of an existing veterinary retailer		<input type="checkbox"/> New site operation
If this is a change of ownership or a change of location, indicate below the previous name, address and license number of veterinary retailer:				
Name:		Address:		License Number:
California law requires that a veterinary retailer permit can only be issued to a board-licensed wholesaler premises. Please provide the following information regarding your wholesale premises at this location.				
Name of Wholesaler:			Permit number:	
Address of Wholesaler:	Number and Street	City	State	Zip Code
Indicate type of ownership of veterinary retailer:				
<input type="checkbox"/> Individual		<input type="checkbox"/> Partnership		<input type="checkbox"/> Corporation
<input type="checkbox"/> Government owned				
Type of Operation:				
<input type="checkbox"/> Wholesaler of dangerous drugs and devices, including controlled substances				
<input type="checkbox"/> Wholesaler of dangerous drugs and devices, without controlled substances				
<input type="checkbox"/> Wholesaler of dialysis drugs and devices				
<input type="checkbox"/> Reverse Distributor				
<input type="checkbox"/> Customs Broker (Import/Export)				

Continue on Reverse

For Office Use Only				
<input type="checkbox"/> Articles of Incorp	<input type="checkbox"/> Financial aff	Approved _____	Cashier # _____	
<input type="checkbox"/> Written policies	<input type="checkbox"/> Stock cert	Denied _____	Date _____	
<input type="checkbox"/> Partnrshp agreement	<input type="checkbox"/> By-laws	Date _____	Amount _____	
<input type="checkbox"/> Sellers' Cert	<input type="checkbox"/> Lease			

Complete the section below of who will be the exemptee-in-charge of veterinary retailer operations at this location.

Exemptee-in-charge's name:		License number:	
Residence address:	City:	State:	Zip Code:

PLEASE READ CAREFULLY AND SIGN BELOW

This application must be approved by the California State Board of Pharmacy before a veterinary food-animal retailer permit will be issued. If changes are made during the application process, you may need to submit a new application with appropriate fees. Fees applied to this application are not transferable and are not refundable.

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of license, and a violation of the Penal Code of California. All items of information in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

The information will be used to determine qualifications for licensure under the California Pharmacy Law. The official responsible for information maintenance is the executive officer, (916) 574-7900, 1625 N. Market Blvd., Suite N219, Sacramento, CA 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 by section 1798.3 of the Civil Code.

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.

Under penalty of perjury, under the laws of the state of California, each person whose signature appears below, certifies and says: (1) He/she is the applicant, or one of the owners or managers of the applicant corporation, named in the foregoing application, duly authorized to make this application on its behalf; (2) that he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) that 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(s) for which this application is made; (4) all supplemental statements are true and accurate.

Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date

This application must be approved by the California State Board of Pharmacy before a permit will be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. Fees applied to this application are not transferable and are not refundable.

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of a license, and is 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 will result in the application being rejected as incomplete.

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ALL OWNERS AND OFFICERS DESIGNATED ON THIS FORM MUST SIGN BELOW.

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an officer of the corporation or limited liability company named on this application form, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) 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; and (4) all supplemental statements are true and accurate.

Print Name _____ Signature _____ Date _____

Print Name _____ Signature _____ Date _____

Print Name _____ Signature _____ Date _____

Print Name _____ Signature _____ Date _____

Print Name _____ Signature _____ Date _____

Print Name _____ Signature _____ Date _____



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STATE AND CONSUMER SERVICES AGENCY
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Parent Corporation or Limited Liability Company Ownership Information

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

Name of parent corporation or limited liability company			Telephone number	
			()	
Address	Number and Street	City	State	Zip Code
Name & address of premises	Number and Street	City	State	Zip Code

Is the parent corporation a subsidiary? Yes No
If yes, name of parent corporation _____ . This parent corporation must also complete a Parent Corporation or Limited Liability Company Ownership information form. Please attach an organization chart.

A. Limited Liability Members or Manager(s) (Use additional sheets if necessary)

Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc., and the license number (if applicable). Non-profit organizations must list the names and titles of persons holding corporate positions.

Title	Name	Residence address & telephone number	Licensed as, license no. and state(s)

For Limited Liability Companies Only: We, the undersigned members, authorize _____
(Name of member)
 to sign all Board of Pharmacy forms, documents and operating conditions on our behalf.

B. Corporate Officers/Directors (Top 5 of each. Use additional sheets if necessary.)

Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc., and the license number (if applicable). Non-profit organizations must list the names and titles of persons holding corporate positions.

Title	Name	Residence address & telephone number	Licensed as, license no. and state(s)

This application must be approved by the California State Board of Pharmacy before a permit will be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. Fees applied to this application are not transferable and are not refundable.

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of a license, and is 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 will 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 N. Market Blvd, Suite N219, Sacramento, California 95834. The information may be transferred to another governmental agency such as a law enforcement agency if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him or her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by section 1798.3 of the Civil Code.

ALL OWNERS AND OFFICERS DESIGNATED ON THIS FORM MUST SIGN BELOW.

Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an officer of the corporation or limited liability company named on this application form, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) 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; and (4) all supplemental statements are true and accurate.

Print Name _____ Signature _____ Date _____

Print Name _____ Signature _____ Date _____

Print Name _____ Signature _____ Date _____

Print Name _____ Signature _____ Date _____

Print Name _____ Signature _____ Date _____

Print Name _____ Signature _____ Date _____



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PARTNERSHIP OR INDIVIDUAL OWNERSHIP INFORMATION

Please print or type

ALL BLANKS MUST BE COMPLETED; IF NOT APPLICABLE, ENTER N/A

Name of premises:	Telephone number ()
Address of premises:	Number and Street City State Zip Code

A. Partnership

If any of the partners listed below is a corporation or limited liability company, form 17A-33 must also be completed for each such entity. Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist, veterinarian, etc., and the license number.

Federal Employer ID Number:*

Name or corporate name	Percentage owned %
Residence or corporate address	*Social security number
Licensed as	License number States licensed in

Name or corporate name	Percentage owned %
Residence or corporate address	*Social security number
Licensed as	License number States licensed in

Name or corporate name	Percentage owned %
Residence or corporate address	*Social security number
Licensed as	License number States licensed in

B. Individual owner

Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian; and the license number.

Name		Do you own 100% of business? Yes <input type="checkbox"/> No <input type="checkbox"/>
Residence address		*Social security number
Licensed as	License number	States licensed in

PLEASE READ CAREFULLY. ALL PARTNERS/OWNERS MUST SIGN BELOW.

This application must be approved by the California State Board of Pharmacy before a pharmacy permit can be issued. If changes are made during the application process, you may need to submit a new application with the appropriate fees. **Fees applied to this application are not transferable and are not refundable.**

Any material misrepresentation in a response to any question is grounds for refusal or subsequent revocation of license, and is a violation of the Penal Code. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

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Under penalty of perjury, under the laws of the State of California, each person whose signature appears below, certifies and says that: (1) he/she is the owner or an officer of the applicant corporation named in the foregoing application, duly authorized to make this application on its behalf and is at least 18 years of age; (2) he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) 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(s) for which this application is made; (4) all supplemental statements are true and accurate; and (5) the transfer application may be withdrawn by either the applicant or the licensee with no resulting liability to the Board of Pharmacy.

Signature of partner or individual owner	Name (please print)	Date
Signature of partner or individual owner	Name (please print)	Date
Signature of partner or individual owner	Name (please print)	Date

*Disclosure of your social security number (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. Your social security number or FEIN will be used exclusively for tax enforcement purposes, for 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 licensure 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 your FEIN, 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.



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REPORT OF EXEMPTEE-IN-CHARGE

There must be one exemptee or pharmacist designated as the exemptee-in-charge for each wholesaler or veterinary food-animal drug retailer (vet retailer)* location. If the exemptee-in-charge leaves the employment of the wholesaler or vet retailer, a new exemptee-in-charge must be designated and reported to the board within 30 days.

The certificates and licenses of all exemptees or pharmacists working at the wholesaler or vet retailer must be current.

(Please print or type)

ALL SECTIONS MUST BE COMPLETED

Name of wholesaler:		Telephone		Permit number (if known)	
Address :	Number and Street	City		State	Zip Code
List below the name, license number and address of the exemptee-in-charge. The designated person must hold a valid exemption certificate or pharmacist license.					
Name				License Number	
Residence address	Street	City		State	Zip Code

I certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing.

 Type or print name of person designating exemptee-in-charge

 Signature of person designating exemptee-in-charge

 Date

 Signature of exemptee-in-charge

 Date

* exemptees for vet retailers must have specific training above that required for wholesale exemptees.



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SELLER'S CERTIFICATION

INSTRUCTIONS: This form is to be completed by the seller and submitted by the prospective owner with the application for a change of ownership. Attach a copy of the pending purchase agreement.

NOTICE: The current permit is not transferable and the current owner of record must maintain operations and control of the licensed premises (including renewing the permit) until a new application is approved by the Board of Pharmacy. The new owner must complete and attach the new application to this document. (Proof of authority to sell by any person, except a person whose name appears on the original permit, must accompany this certification.)

(Please print or type)

All blanks must be completed; if not applicable enter N/A

This will certify that _____
 (name of individual, partnership* or corporation – "seller")

has agreed that on _____ "seller" shall transfer _____
 month/day/year (all, half, etc.)

of the right, title and interest in _____ (name of premises) _____ (permit number)

located at _____ (street number and name) _____ (city) _____ (state) _____ (zip code)

To _____ (name of buyer(s))

*IF A PARTNERSHIP, LIST THE NAMES OF ALL PARTNERS (all names must be listed)

On completion of this sale and approval of the new permit, the original permit, and the current renewal must be returned to the California State Board of Pharmacy for cancellation, before the new permit will be released.

Under penalty of perjury under the laws of the State of California, each person whose signature appears below certifies and says that: (1) he/she is the licensee, general partner or an executive officer of the corporate licensee named in this Seller's Certification, duly authorized to make this sale; and (2) all statements made in this Seller's Certification are true and correct to the best of his/her knowledge. If the seller is a partnership, all partners must sign below.

Signature of Seller	Name (please print)	Title	Date
Signature of Seller	Name (please print)	Title	Date
Signature of Seller	Name (please print)	Title	Date



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Financial Affidavit in Support of Application

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

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

Name of Corporation, Partnership or Individual Owner:				
Address of Corporation, Partnership or Individual Owner:				
Name of Pharmacy, Hospital, Wholesaler, etc:				
Premises Address:	Number and Street	City	Zip Code	Telephone Number:

Indicate what part of the total investment will be in cash, and from what source(s) it will be or has been derived. **Please attach documentation.** \$ _____

Source: _____

List all other sources of funding for the pharmacy and how it will be paid. Provide the name, address, telephone number and amount. Use additional sheets if necessary. \$ _____

Source: _____

If the pharmacy is franchised, list the name of franchisor:

Who will be the **primary** wholesaler for dangerous drugs and/or dangerous devices? Please attach a photocopy of the **approved** application filed with the wholesaler.

Name of primary Wholesaler	Telephone number
----------------------------	------------------

Address of Wholesaler	Number & Street	City	State	Zip Code
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Who will be the **secondary** wholesaler for dangerous drugs and/or dangerous devices? Please attach a photocopy of the **approved** application filed with the wholesaler.

Name of secondary Wholesaler	Telephone number
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Address of Wholesaler	Number & Street	City	State	Zip Code
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Business Bank Name & Address (list all accounts for the pharmacy)	Telephone Number	Account Number	Balance of Account

Please submit a copy of most recent bank statement for each bank account listed above.

List all individuals authorized to sign on business bank account.

Signature	Name (please print)	Title

Name of bookkeeper/accountant for applicant premises:	Telephone Number ()
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Address of bookkeeper/accountant:	Number and Street	City	State	Zip Code
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Estimated annual gross sales \$ _____	Estimated annual purchases \$ _____
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APPLICANT(S) AUTHORIZATION FOR DISCLOSURE OF FINANCIAL RECORDS

For a period of nine months, from this date, for the purpose of authorizing the Board of Pharmacy to conduct an investigation on my/our qualifications pursuant to section 4207 of the Business and Professions Code, I/we 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, notes and loan documents, deposit and withdrawal records, and escrow documents of my/our financial institution(s) or any financial records established in connection with this business.

I/we 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/our bookkeeper/accountant or with the escrow holder. I/we agree to furnish current financial information on the annual renewal if requested by the Board of Pharmacy. Applicant understands that falsification of the information on this form may constitute grounds for denial or revocation of the license.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers and representations made in the foregoing application, including all supplementary statements.

If corporation owned, one corporate officer must sign; if partnership owned, all partners must sign.

Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date

Date	Place	Attest (Notary Public)
------	-------	------------------------



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Individual Financial Affidavit

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

Full Name:	Last	First	Middle	Telephone number
				()
Residence Address	Number and Street	City	State	Zip Code
Premises Address	Number and Street	City	State	Zip Code
				Telephone number
				()
You must indicate <u>one or more</u> of the following:				
<input type="checkbox"/> I am making a contribution: total amount \$_____ cash amount \$_____				
<input type="checkbox"/> I am contributing labor/expertise only valued at: \$_____				
<input type="checkbox"/> I am receiving a loan: total amount \$_____ (please attach copy of loan agreement)				
<input type="checkbox"/> I am making a loan: total amount \$_____ (please attach copy of loan agreement)				
<input type="checkbox"/> I am not making a contribution in any form.				

SOURCE OF FUNDS USED TO FINANCE BUSINESS

INSTRUCTIONS: Fully explain the source of your financial contributions (e.g. stock/bonds, real estate). If cash funds are from savings, indicate where the money was or is kept. If the source is from the sale of property, indicate what was sold, the address (if real estate), the name and address of the buyer, and the net proceeds from the sale. If a loan is involved, show the date, amount, terms, security, name and address of the lender. Describe any other sources of funds such as inheritances or gifts. Documentation may be requested.

SAVINGS (Please use additional sheets if necessary)

	ITEM 1	ITEM 2
Financial Institution(s)		
Address		
Amount		
Account Number		
Source of savings		

CHECKING (Please use additional sheets if necessary)

	ITEM 1	ITEM 2
Financial Institution(s)		
Address		
Amount		
Account Number		
Source of checking		

LOANS & CREDIT APPLICATIONS FOR THIS BUSINESS**(Please use additional sheets if necessary)**

ITEM 1

ITEM 2

Date(s)		
Amount(s)		
Term(s)		
Item(s) secured		
Security(s)		
Lender(s)		

SALE OF PROPERTY TO FINANCE THIS BUSINESS (Please use additional sheets if necessary)

ITEM 1

ITEM 2

Type		
Location(s)		
Date sold		
Buyer		
Net proceeds		
Other source(s)		

Will funding be provided in any amount from an individual, partnership or corporation whose professional or vocational license has been revoked, denied or in any other manner disciplined by a regulatory board in California or any other state?

Yes No

If yes, please explain fully below (attach additional sheets if necessary). Attach copies of all disciplinary orders.

Please read and sign below in the presence of a Notary Public.

For a period of nine months from this date and pursuant to section 4207 of the Business and Professions Code, 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 occur 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 understand that falsification of the information on this form may constitute grounds for denial or revocation of the license.

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

Applicant's signature

Title Date

Place Attest (Notary Public)



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

STATE AND CONSUMERS AFFAIRS AGENCY
 DEPARTMENT OF CONSUMER AFFAIRS
 GOVERNOR EDMUND G. BROWN JR.

PERSONAL BACKGROUND AFFIDAVIT

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.

If fingerprints will be taken outside of California, you must submit one set of two completed fingerprint cards and the fingerprint processing fee of \$49.00. If prints will be taken in California, you must submit a copy of the *Request for Live Scan Service Form* verifying that fingerprints have been scanned and all applicable fees have been paid.

Please print or type

Full name:	Last	First	Middle	Telephone Number:
				()
Address:	Number and Street	City	State	Zip
Date of birth: (MM/DD/YY)	*Social Security number:	Previous name(s) – include maiden name; also known as (AKA's); "aliases":		

Name of applicant (business name):	Applicant telephone number:
Address of applicant:	Number and Street City State Zip

My position with the applicant is: (Check all that apply)

Sole owner Partner Officer Stockholder Member

Other please specify _____

1. Are you currently, or have you in the previous five years, been a manager, administrator, owner, member, officer, director, associate, or partner of any partnership, corporation, firm, or association whose application for a license has been denied or whose license has been revoked, suspended, or been placed on probation in California or any other state? Yes No

If the answer is "yes," please provide the following information for each action taken. Please include cancelled permits. (Use additional sheets if necessary.)

Company Name:	Type of License:	License #:	State:	Position Held:
Type of Action:				Year of Action:

Company Name:	Type of License:	License #:	State:	Position Held:
Type of Action:				Year of Action:

Company Name:	Type of License:	License #:	State:	Position Held:
Type of Action:				Year of Action:

2. Have you ever had a professional or vocational license denied, suspended, revoked, voluntarily surrendered, placed on probation or other disciplinary action taken by this or any other governmental authority in this state, any other state or by a federal regulatory agency? Yes No

If the answer is "yes," please provide company name, permit type, action, year of action and state. (Use additional sheets if necessary.)

Type of License:	License #:	Type of Action:	Year of Action:	State:
Type of License:	License #:	Type of Action:	Year of Action:	State:
Type of License:	License #:	Type of Action:	Year of Action:	State:

3. Have you ever been in violation of any provisions of California pharmacy law, including regulations? Yes No

If "yes," please list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.)

Type of License:	License #:	State:
Type of Action:		Year of Action:

Type of License:	License #:	State:
Type of Action:		Year of Action:

Type of License:	License #:	State:
Type of Action:		Year of Action:

Type of License:	License #:	State:
Type of Action:		Year of Action:

4. Have you ever been convicted of, or pled no contest to, a violation of any law of a foreign country, the United States or of any state or local ordinances? You must include all **misdemeanor and felony convictions**, regardless of the age of the conviction, **including those** which have been set aside and/or dismissed under Penal Code sections 1000 or 1203.4. (Traffic violations of \$500 or less need not be reported.) Yes No

If "yes," please attach the relevant arrest and court documents.

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

If "yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled substances? Please attach a statement of explanation.

Please read carefully and sign below.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license.

I hereby certify under penalty of perjury under the laws of the State of California that all statements, answers and representations made in the foregoing personal background affidavit, including all supplementary statements are true and accurate and that I personally completed this personal background affidavit.

Signature

Date

Print Name

Title

*Disclosure of your social security number is mandatory. Business and Professions Code section 30 and Public Law 94-455 (42 USC 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.



BUSINESS BACKGROUND AFFIDAVIT

The information on this form is specific to the business applicant, not the individual completing the form. This form is to be completed by an individual authorized to act for or bind the corporation. All blanks must be completed; **if not applicable enter "N/A."** Failure to furnish complete explanations, or omission of any information, will delay the processing of your application.

This individual completing this form must:

- Complete a Personal Background Affidavit (17A-37), and
- One set of completed fingerprint cards (2 cards) and the fingerprint processing fee of \$66.00, if prints are taken outside California; or, if prints are taken in California, a copy of the *Request for Live Scan Service Form* verifying that fingerprints have been scanned and all applicable fees have been paid

Please print or type

Business Name			Telephone Number:	
			()	
Address:	Number and Street	City	State	Zip

Name of applicant (business name):			Applicant telephone number:	
Address of applicant:	Number and Street	City	State	Zip

My position with the applicant is: Sole owner <input type="checkbox"/> Partner <input type="checkbox"/> Officer <input type="checkbox"/> Member <input type="checkbox"/> Stockholder <input type="checkbox"/>				
(Check all that apply)				

1. Are you currently, or have you in the previous five years, been an owner, member, or partner of any partnership, corporation, firm, or association whose application for a license has been denied or whose license has been revoked, suspended, or been placed on probation in California or any other state? Yes No

If the answer is "yes," please provide the following information for each action taken. Please include cancelled permits. (Use additional sheets if necessary.)

Company Name:	Type of License:	License #:	State:	Position Held:
Type of Action:				Year of Action:

Company Name:	Type of License:	License #:	State:	Position Held:
Type of Action:				Year of Action:

Company Name:	Type of License:	License #:	State:	Position Held:
Type of Action:				Year of Action:

2. Have you ever been in violation of any provisions of California pharmacy law, including regulations? Yes No

If "yes," please list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.)

Company Name:	Type of License:	License #: State:		Position Held:
Type of Action:				Year of Action:

Company Name:	Type of License:	License #: State:		Position Held:
Type of Action:				Year of Action:

Company Name:	Type of License:	License #: State:		Position Held:
Type of Action:				Year of Action:

3. Have you ever been convicted of, or pled no contest to, a violation of any law of a foreign country, the United States or of any state or local ordinances? You must include all **misdemeanor and felony convictions**, regardless of the age of the conviction, **including those** which have been set aside and/or dismissed under Penal Code sections 1000 or 1203.4. (Traffic violations of \$500 or less need not be reported.) Yes No

If "yes," please attach the relevant arrest and court documents.

Please read carefully and sign below.

Under penalty of perjury, under the laws of the State of California, I certify and affirm that: (1) I am a person authorized to act for and bind the applicant and I am at least 18 years of age; (2) I have read the foregoing background certification and know the contents thereof and each and every statement made therein is true; (3) I understand that falsification of any information in this affidavit may constitute grounds for denial or subsequent revocation of the license; (4) no other 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 affidavit is made; all supplemental statements filed with this affidavit are true, complete and accurate.

Signature

Print Name

Title

Date

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

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

NOTE TO APPLICANT and LIVE SCAN OPERATOR: The applicant's name, date of birth, and US social security number must be entered in at the time of the Live Scan transmission in order for the results to be accepted by the Board of Pharmacy. If any of the 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:** Print your name as it appears on your U.S. government photo identification (ID). The name on your ID must match identically to the name you enter on your application. If you change your name, you are required to notify the board within 30 days of the change.
- **Other Name (AKA):** Include 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:** State or County
- **Social Security Number (Mandatory):** Your US Social Security Number. It is your responsibility to notify the Live Scan operator that your US social security number is mandatory to be included in the submission for the Board of Pharmacy. Failure to ensure that your social security number is included on the submission will result in you having to be re-fingerprinted and pay all fees associated with the processing of your fingerprints.
- **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.1) 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.



REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI (Code assigned by DOJ)

Authorized Applicant Type

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:

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

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