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

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

PARTNERSHIP OWNER INSTRUCTIONS

An application for a wholesaler must include:

- Completed Application for Wholesaler License (form 17A-68)
- $550 application processing fee made payable to the "California State Board of Pharmacy"
- Report of the designated representative-in-charge* (form 17A-3)
- Personal Background Affidavit for the top five partners listed on the application** (form 17A-37)
- Copy of *Request for Live Scan Service Form* for the top five partners listed verifying that fingerprints have been scanned and all applicable fees have been paid.
- License verification from each state licensing authority where a license has been granted (form 17M-17)
- Business Background Affidavit (form 17A-18).
- Executed Partnership Agreement
- Executed Seller's Certification (form 17A-8), if the application is for a change of ownership of an existing license.

This application should be completed and signed by an individual authorized to act for and bind the partnership, such as a partner (general partner, for a limited partnership) or principal/executive officer (e.g., president, CEO, chairperson).

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

**In addition, if a partner listed on the application is an entity, not a natural person, a Business Background Affidavit (form 17A-18) must also be completed by an individual authorized to act for and bind the entity. This person must also complete a Personal Background Affidavit (form 17A-37) and submit a copy of *Request for Live Scan Service Form* verifying that your fingerprints have been scanned and all applicable fees have been paid.

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APPLICATION FOR WHOLESALER LICENSE

Partnership Owner

A. Applicant Information

Please print or type **ALL BLANKS MUST BE COMPLETED; IF NOT APPLICABLE, ENTER N/A**

Name of Applicant (Business Name):			Applicant telephone number: ( )	
Address of Applicant:	Number and Street	City	State	Zip Code

Indicate whether this application is for:

☐ New Application ☐ Change of ownership of an existing wholesaler licensed with the California Board of Pharmacy
Effective date of transaction: _____

If this is a change of ownership, indicate below the previous name, address and license number of the wholesaler.

Name:			License number:	
Address:	Number and Street	City	State	Zip

Who will be the designated representative-in-charge* at this location.

Name of Designated representative-in-charge*:	License Number

Name, business address and telephone number of person authorized to clarify information provided on this application

Name:			Telephone:	
Mailing Address:	Street	City	State	Zip

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

For Office Use Only		
Processed By: _____ Date: _____	Approved _____ Denied _____ Date _____	Cashier # _____ Date _____ Amount_____

B. Partnership Information

List the persons with the five largest ownership interests in the partnership below. Under the heading "License Held" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist, veterinarian, attorney or accountant, etc., and the license number (if applicable).

Each person listed below must also:

- Complete and submit a Personal Background Affidavit (Form 17A-37).
- Submit a copy of the *Request for Live Scan Service Form* verifying that fingerprints have been scanned and all applicable fees have been paid.

If a partner is a partnership, limited liability company or corporation, the partner must:

- Complete and submit Business Background Affidavit (Form 17A-18).
- Specify an individual authorized to act for and bind the partnership who must
  1. Complete and submit a Personal Background Certification (Form 17A-37).
  2. Submit a copy of the *Request for Live Scan Service Form* verifying that fingerprints have been scanned and all applicable fees have been paid.

Name:			Telephone number ( )
Address: Number and Street City State Zip Code			
Title:	License Held (type and state):	License Held (type and state):	License Held (type and state):
Name of Authorized Agent:			

Name:			Telephone number ( )
Address: Number and Street City State Zip Code			
Title:	License Held (type and state):	License Held (type and state):	License Held (type and state):
Name of Authorized Agent:			

Name:			Telephone number ( )
Address: Number and Street City State Zip Code			
Title:	License Held (type and state):	License Held (type and state):	License Held (type and state):
Name of Authorized Agent:			

Name:			Telephone number ( )
Address: Number and Street City State Zip Code			
Title:	License Held (type and state):	License Held (type and state):	License Held (type and state):
Name of Authorized Agent:			

C. Background Information

List all state(s) in which the applicant is or has been licensed as a wholesaler, pharmacy, manufacturer, or repackager (attach additional sheets if necessary):

State	License Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	
			Yes ☐ No ☐	If yes, you must attach a written explanation giving full details. Failure to provide an explanation will delay the processing of your application.
State	License Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	
			Yes ☐ No ☐	If yes, you must attach a written explanation giving full details. Failure to provide an explanation will delay the processing of your application.
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			Yes ☐ No ☐	If yes, you must attach a written explanation giving full details. Failure to provide an explanation will delay the processing of your application.
State	License Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	
			Yes ☐ No ☐	If yes, you must attach a written explanation giving full details. Failure to provide an explanation will delay the processing of your application.

*Disclosure of a social security number (or federal employer identification number ["FEIN"], if 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 a social security number. A social security number or FEIN will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code and Section 17520 of the Family 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. Failure to disclose a social security number or a FEIN, this application for initial or renewal license will not be processed AND will be reported to the Franchise Tax Board, which may assess a $100 penalty.

D. Certification of Applicant – Please read carefully and sign below

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

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. 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.

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, 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 by sections 1798.38 and 1798.40 of the Civil Code.

Signature Block

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 applicant and know the contents thereof and each and every statement made therein is true and correct; (3) I understand that falsification of any information in this application may constitute grounds for denial or subsequent revocation of the license; (4) 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 (5) all supplemental statements filed with this application are true, complete, and accurate.

Signature of Person Authorized to Submit Application	Name (please print)	Title	Date

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REPORT OF DESIGNATED REPRESENTATIVE-IN-CHARGE

There must be one designated representative or pharmacist chosen as the designated representative-in-charge for each wholesaler or veterinary food-animal drug retailer (vet retailer)* location.

If the designated representative-in-charge leaves the employment of the wholesaler or vet retailer, a new designated representative-in-charge must be reported to the board within 30 days. DO NOT USE THIS FORM TO REPORT A CHANGE. Changes in the designated representative-in-charge must be reported on a Change of designated representative-in-Charge (form 17AE-1).

The licenses of all designated representatives or pharmacists working at the wholesaler or vet retailer must be current.

(Please print or type) **ALL SECTIONS MUST BE COMPLETED**

Name of wholesaler:				Permit number (if known)
Address :	Number and Street	City	State	Zip Code
Telephone Number: ( )	Name of person reporting designated representative-in-charge:			
********** **DESIGNATED REPRESENTATIVE INFORMATION** **********				
Full name: Last	First	Middle		EXC license No:
Residence Address:	Number and Street	City	State	Zip Code
Telephone Number: ( )	Date of birth: (Month, Day, Year)	*Social Security number:		
Previous name(s) – include maiden name, also known as (AKA's), "aliases":				

I certify under penalty of perjury under the laws of the State of California that all statements, answers and representations made in the foregoing are true and accurate.

Signature of person reporting designated representative-in-charge _____ Date _____

Signature of designated representative-in-charge _____ Date _____

*Designated representative for vet retailers must have specific training in addition to that required for wholesale designated representatives.

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

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BUSINESS BACKGROUND AFFIDAVIT

This form is to be completed by an individual authorized to act for or bind the partnership. 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 must also complete a Personal Background Affidavit (17A-37).

If you reside out of state, submit one set of two completed fingerprint cards and the fingerprint processing fee of $66.00. If you reside 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

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 ☐ Partner ☐ Officer ☐ Member ☐ Stockholder (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 _____

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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 you reside out of state, submit one set of two completed fingerprint cards and the fingerprint processing fee of $66.00. If you reside 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: (Month, Day, Year)	*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 individual personal affidavit, including all supplementary statements are true and accurate and that I personally completed this personal affidavit.

Signature	Print Name
Title	Date

*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.

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LICENSE VERIFICATION

INSTRUCTIONS: This form is to be completed by the licensing authority in each state where you are licensed. The form must be completed even if the license is no longer current or active. Please return the state verified form with your application.

TO BE COMPLETED BY APPLICANT

(Please print or type)

Name of Applicant			Telephone Number	
			( )	
Address (Street and Number)	City		State	Zip Code
Title of License		License Number	Issue Date	Exp. Date

TO BE COMPLETED BY STATE BOARD OFFICE VERIFYING LICENSURE

The person listed above has applied for a wholesale license in California. Before further consideration is given this application, we 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.**

LICENSURE VERIFICATION PROVIDED BY THE STATE OF _____

Name		License Number
Type of License Issued:	Date License Issued	Exp. Date of License
License Status:		
Active ☐ Inactive ☐ Other ☐ If other, please explain: _____		

Has the licensee been found guilty of any violation for which disciplinary action was taken? Yes ☐ No ☐

If disciplinary action has been taken against this licensee, please provide this office with all the available documentation regarding the action.

_____
Signature

Board Seal

_____
Title

_____
Date

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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. 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

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.

1. **Job Title or Type of License, Certification, or Permit:** Enter the type of license, certification or permit for which you are applying. Appropriate license types include pharmacist, pharmacy technician, intern pharmacist, exemptee, or if an owner or officer of a pharmacy, hospital, clinic, wholesaler or hypodermic permit enter appropriate title of the facility.
2. **Name of Applicant:** Enter your last name, first name and middle name. Do not use initials or name abbreviations.
3. **AKA:** Enter all other names you have used, including your maiden name.
4. **CDL No:** Your California Driver's License Number.
5. **DOB:** Your date of birth (month/day/year).
6. **SEX:** Your gender (male or female).
7. **HT:** Your height in feet and inches.
8. **WT:** Your weight in pounds.
9. **Misc. No.:** Enter other identifying numbers. (e.g., Other State Driver's License Number)
10. **EYE Color:** Color of your eyes
11. **HAIR Color:** Color of your hair
12. **Home Address:** Your residence address
13. **POB:** Enter your place of birth.
14. **SOC:** Enter your Social Security Number

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

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (DOJ processing fee of $32, FBI processing fee of $24, 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.

17M-15 (9/05)

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071 (Code assigned by DOJ)

Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy Wholesaler - Section 4305.5

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

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

1625 N. Market Blvd, Suite N219
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento, CA 95834
City State Zip Code

(916) 574-7900
Contact Telephone No.

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

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

If resubmission, list Original ATI No. _____

Level of Service DOJ ☑ FBI ☑

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

N/A
Employer Name

N/A
Street No. Street or PO Box

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

N/A
City State Zip Code

N/A
( )
Agency Telephone No. (Optional)

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

Transmitting Agency ATI No. Amount Collected/Billed

ORIGINAL -Live Scan Operator; SECOND COPY-Board of Pharmacy; THIRD COPY-Applicant

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071
Code assigned by DOJ

Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy Wholesaler - Section 4305.5
(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

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

1625 N. Market Blvd, Suite N219
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento, CA 95834
City State Zip Code

(916) 574-7900
Contact Telephone No.

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

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____
Date of Birth

SEX: ☐ Male ☐ Female

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____
Height

WT: _____
Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☑

If resubmission, list Original ATI No. _____

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

N/A
Employer Name

N/A
Street No. Street or PO Box

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

N/A
City State Zip Code

N/A
( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____
Name of Operator

Date _____

Transmitting Agency

ATI No.

Amount Collected/Billed

ORIGINAL-Live Scan Operator; SECOND COPY Board of Pharmacy; THIRD COPY-Applicant

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071 (Code assigned by DOJ)

Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy Wholesaler - Section 4305.5

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

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

1625 N. Market Blvd, Suite N219
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento, CA 95834
City State Zip Code

(916) 574-7900
Contact Telephone No.

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

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

If resubmission, list Original ATI No. _____

Level of Service DOJ ☑ FBI ☑

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

N/A
Employer Name

N/A
Street No. Street or PO Box

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

N/A
City State Zip Code

N/A
( )
Agency Telephone No. (Optional)

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

Transmitting Agency ATI No. Amount Collected/Billed

ORIGINAL-Live Scan Operator; SECOND COPY - Board of Pharmacy; THIRD COPY - Applicant

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

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

A wholesaler license is required by any business that distributes, brokers or transacts the sale or return of dangerous drugs or dangerous devices into or within California to other wholesalers, practitioners or pharmacies. Changes in several sections of California Pharmacy law, specifically relating to the wholesaling of dangerous drugs and devices in California will go into effect January 1, 2006.

The most significant change will be the addition of a $100,000 surety bond made payable to the Pharmacy Board Contigency Fund. This requirement becomes effective January 1, 2006. The specific requirements are highlighted below.

- Any applicant for initial licensure or license renewal as a wholesaler or nonresident wholesaler (formerly referred to as an out-of-state distributor) must submit a surety bond of $100,000 made payable to the Pharmacy Board Contigency Fund.

- In lieu of the bond, applicants may submit other equivalent means of security acceptable to the board, including a standby letter of credit or cash deposit in lieu of bond. These other means of security must be payable to the Pharmacy Board Contigency Fund.

- A single surety bond or other equivalent means of security will cover all licensed sites under common ownership.

- The board may accept a surety bond of $25,000 if the annual gross receipts for the previous tax year are $10 million or less.

Note: A licensee who has posted a $25,000 bond but has been disciplined by any state or federal agency or issued an administrative fine under California Pharmacy Law may be required to submit a $100,000 surety bond.

Exception: Certain manufacturers licensed with the FDA who are also licensed as wholesalers or nonresident wholesalers by the California State Board of Pharmacy to distribute exclusively their own product in California are exempt from these requirements.

The exact language for the Business and Professions Code sections dealing with the bonding requirements can be found in California Business and Professions Code sections 4162 and 4162.5. (See the board's Web site under "Pharmacy Law and Regulations.") The board's newsletter, "*The Script,*" for October 2005 discusses some of the changes affecting businesses that wholesale dangerous drugs and devices within and into California.

If you have any questions please e-mail Brenda Cartwright at Brenda_Cartwright@dca.ca.gov or Anne Sodergren at Anne_Sodergren@dca.ca.gov.

Following please find the approved surety bond and other equivalent means of security forms.

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

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

WHOLESALER or NONRESIDENT WHOLESALER SURETY BOND

Business and Professions Code Sections 4162, 4162.5

Bond No. _____

Application/License No. _____

KNOW ALL PERSONS BY THESE PRESENTS:

That, _____ (Applicant), doing business as a wholesaler, whose address for purposes of service is _____ (address of Applicant), as PRINCIPAL, and _____ (Surety Company), a corporation organized under the laws of _____ (state of incorporation) and authorized to transact a general surety business in the State of California, whose address for purposes of service is, _____ (address for Surety Company) as SURETY, are held and firmly bound unto the People of the State of California, and to the Pharmacy Board Contingent Fund, for the penal sum of ONE HUNDRED THOUSAND DOLLARS ($100,000.00), for which payment we bind ourselves, our heirs, executors, administrators, successors and assigns jointly and severally, by these presents. This bond term shall become effective on _____ (effective date)

WHEREAS, the provisions of Sections 4162 and/or 4162.5, Business and Professions Code, require that the Applicant file or have on file with the California State Board of Pharmacy (Board) a bond in the sum of $100,000.00 payable to the Pharmacy Board Contingent Fund, and this bond is executed and tendered in accordance therewith. The purpose of the bond is to secure payment of any administrative fines imposed on Applicant by the Board, and/or any cost recovery owed by Applicant to the Board under Business and Professions Code Section 125.3.

NOW THEREFORE, the conditions of the foregoing obligation are that if the Applicant shall comply with and be subject to the provisions of Division 2, Chapter 9 (commencing with Section 4000) of the Business and Professions Code, then this obligation shall be null and void; otherwise it shall remain in full force and effect.

PROVIDED HOWEVER, this bond is subject to the following express conditions:

(1) This bond shall be deemed continuous in form and shall remain in full force and effect and shall run concurrently with the license period for which the license is granted and each and every succeeding license period or periods for which said Applicant may be licensed, after which liability hereunder shall cease except as to any liability or indebtedness therefore incurred or accrued hereunder.

(2) This bond is executed by the Applicant and the Surety to comply with the provisions of Division 2, Chapter 9 (commencing with Section 4000) of the Business and Professions Code and of Chapter 2, Title 14, Part 2 (commencing with Section 995.010) of the Code of Civil Procedure and said bond shall be subject to all of the terms and provisions thereof.

(3) The Surety, its successors and assigns, are jointly and severally liable on the obligations of the bond, in conformity with Chapter 2, Title 14, Part 2 (commencing with Section 995.010) of the Code of Civil Procedure and Division 2, Chapter 9 (commencing with Section 4000) of the Business and Professions Code.

(4) The limitations of the liability of the Surety and the conditions of the bond are set forth in Business and Professions Code Sections 4162 and 4162.5. The Board may make a claim against the bond for any administrative fine imposed on Applicant by the Board pursuant to Division 2, Chapter 9 (commencing with Section 4000) of the Business and Professions Code, or for any cost recovery ordered payable by Applicant pursuant to Business and Professions Code Section 125.3, if Applicant fails to pay to the Board the fine or cost recovery within thirty (30) days of the order imposing the fine or cost recovery. Any such claim may be made directly to the Surety and need not be preceded by the filing of any action in a proper court. Payment of any such claim shall be payable to the Pharmacy Board Contingent Fund.

(5) The aggregate liability of the Surety hereunder on all claims whatsoever shall not exceed the penal sum of this bond in any event.

(6) This bond may be cancelled by the Surety in accordance with the provisions of Article 13 (commencing with Section 996.310), Chapter 2, Title 14, Part 2 of the Code of Civil Procedure.

(7) The Applicant and Surety may be served with notices, papers and other documents under the provisions of Chapter 2, Title 14, Part 2 (commencing with Section 995.010) of the Code of Civil Procedure at the addresses given above.

I certify (or declare) under penalty of perjury, under the laws of the State of California, that I have executed the foregoing bond on behalf of the Surety under an unrevoked power of attorney.

In witness whereof, each party to this bond has caused it to be executed on this ___ day of_____, 20_____.

☐ PRESCRIPTION DRUG WHOLESALER
or
☐ OUT-OF-STATE PRESCRIPTION DRUG WHOLESALER

_____
Principal's Authorized Representative

SIGNED and SEALED in the presence of:

_____
Witness

_____
Witness

SURETY COMPANY

_____
Surety Company's Representative

_____, *Attorney-in-Fact*
print name

SIGNED and SEALED in the presence of:

_____
Witness

_____
Witness

Countersigned by:

_____
California Resident Agent

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

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

WHOLESALER or NONRESIDENT WHOLESALER SURETY BOND

FOR ENTITIES WITH GROSS ANNUAL RECEIPTS OF $10,000,000 OR LESS

Business and Professions Code Sections 4162, 4162.5

Bond No. _____

Application/License No. _____

KNOW ALL PERSONS BY THESE PRESENTS:

That, _____ (Applicant), doing business as a wholesaler, whose address for purposes of service is _____ (address of Applicant), as PRINCIPAL, and _____ (Surety Company), a corporation organized under the laws of _____ (state of incorporation) and authorized to transact a general surety business in the State of California, whose address for purposes of service is, _____ (address for Surety Company) as SURETY, are held and firmly bound unto the People of the State of California, and to the Pharmacy Board Contingent Fund, for the penal sum of TWENTY FIVE THOUSAND DOLLARS ($25,000.00), for which payment we bind ourselves, our heirs, executors, administrators, successors and assigns jointly and severally, by these presents. This bond term shall become effective on _____ (effective date)

WHEREAS, the provisions of Sections 4162 and/or 4162.5, Business and Professions Code, require that the Applicant file or have on file with the California State Board of Pharmacy (Board) a bond in the sum of $25,000.00 payable to the Pharmacy Board Contingent Fund, and this bond is executed and tendered in accordance therewith. The purpose of the bond is to secure payment of any administrative fines imposed on Applicant by the Board, and/or any cost recovery owed by Applicant to the Board under Business and Professions Code Section 125.3.

NOW THEREFORE, the conditions of the foregoing obligation are that if the Applicant shall comply with and be subject to the provisions of Division 2, Chapter 9 (commencing with Section 4000) of the Business and Professions Code, then this obligation shall be null and void; otherwise it shall remain in full force and effect.

PROVIDED HOWEVER, this bond is subject to the following express conditions:

(1) This bond shall be deemed continuous in form and shall remain in full force and effect and shall run concurrently with the license period for which the license is granted and each and every succeeding license period or periods for which said Applicant may be licensed, after which liability hereunder shall cease except as to any liability or indebtedness therefore incurred or accrued hereunder.

(2) This bond is executed by the Applicant and the Surety to comply with the provisions of Division 2, Chapter 9 (commencing with Section 4000) of the Business and Professions Code and of Chapter 2, Title 14, Part 2 (commencing with Section 995.010) of the Code of Civil Procedure and said bond shall be subject to all of the terms and provisions thereof.

(3) The Surety, its successors and assigns, are jointly and severally liable on the obligations of the bond, in conformity with Chapter 2, Title 14, Part 2 (commencing with Section 995.010) of the Code of Civil Procedure and Division 2, Chapter 9 (commencing with Section 4000) of the Business and Professions Code.

(4) The limitations of the liability of the Surety and the conditions of the bond are set forth in Business and Professions Code Sections 4162 and 4162.5. The Board may make a claim against the bond for any administrative fine imposed on Applicant by the Board pursuant to Division 2, Chapter 9 (commencing with Section 4000) of the Business and Professions Code, or for any cost recovery ordered payable by Applicant pursuant to Business and Professions Code Section 125.3, if Applicant fails to pay to the Board the fine or cost recovery within thirty (30) days of the order imposing the fine or cost recovery. Any such claim may be made directly to the Surety and need not be preceded by the filing of any action in a proper court. Payment of any such claim shall be payable to the Pharmacy Board Contingent Fund.

(5) The aggregate liability of the Surety hereunder on all claims whatsoever shall not exceed the penal sum of this bond in any event.

(6) This bond may be cancelled by the Surety in accordance with the provisions of Article 13 (commencing with Section 996.310), Chapter 2, Title 14, Part 2 of the Code of Civil Procedure.

(7) The Applicant and Surety may be served with notices, papers and other documents under the provisions of Chapter 2, Title 14, Part 2 (commencing with Section 995.010) of the Code of Civil Procedure at the addresses given above.

I certify (or declare) under penalty of perjury, under the laws of the State of California, that I have executed the foregoing bond on behalf of the Surety under an unrevoked power of attorney.

In witness whereof, each party to this bond has caused it to be executed on this ___ day of_____, 20_____.

☐ PRESCRIPTION DRUG WHOLESALER
or
☐ OUT-OF-STATE PRESCRIPTION DRUG WHOLESALER

_____
Principal's Authorized Representative

SIGNED and SEALED in the presence of:

_____
Witness

_____
Witness

SURETY COMPANY

_____
Surety Company's Representative

_____, *Attorney-in-Fact*
print name

SIGNED and SEALED in the presence of:

_____
Witness

_____
Witness

Countersigned by:

_____
California Resident Agent

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

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

Name of Financial Institution:_____

Address:_____

City, State Zip:_____

Name of Applicant/Licensee:_____

Address:_____

City, State Zip:_____

IRREVOCABLE STANDBY LETTER OF CREDIT NO. _____ DATED: _____

To Beneficiary:

California State Board of Pharmacy
1625 N. Market Blvd, Suite N219
Sacramento, CA 95834
Attention: Executive Officer

1. At the request and on the instructions of _____ (Applicant/Licensee), we _____ (Financial Institution) hereby establish in favor of the Beneficiary, the California State Board of Pharmacy (Board), this Irrevocable Standby Letter of Credit (Credit) in the principal sum of $_____.

2. This Credit is and has been established for the sole benefit of the Board pursuant to the terms of Business and Professions Code sections 4162 and/or 4162.5, pertaining to the initial or renewal application filed by the Applicant/Licensee.

3. This credit is intended by the parties to serve as a security device for the performance by Applicant/Licensee of its obligations under Chapter 9, Division 2, commencing with section 4000 of the Business and Professions Code.

4. Upon the occurrence of any default by Applicant/Licensee as determined by the Board in its sole discretion under this agreement, the Board shall be entitled to draw upon this credit by presentation of a duly executed CERTIFICATE FOR DRAWING in substantially the same form as Attachment A, attached hereto, at our office located at _____ (Address of financial institution).

5. The CERTIFICATE shall be completed and signed by an "Authorized Representative" as defined in paragraph 12. Presentation by the Board of a completed CERTIFICATE may be made in person or by registered mail, return receipt requested.

6. Upon presentation of a duly executed CERTIFICATE as above provided, payment shall be made to the Board, or to an account designated by the Board, in immediately available funds, at such time and place as the Board shall specify.

7. Funds may be drawn in one or more drawings not to exceed the principal sum.

8. If demand for payment does not conform to the terms of this CREDIT, we shall give the Board prompt notice that the demand for payment was not effected in accordance with the terms of this CREDIT, state the reasons therefore, and await further instructions.

9. Upon being notified that the demand for payment was not effected in conformity with the CREDIT, the Board may correct any such non-conforming demand for payment.

10. All drawings under this CREDIT shall be paid with our funds. Each drawing honored by us hereunder shall reduce, pro tanto, the principal sum. By paying to the Board an amount demanded in accordance herewith, we make no representations as to the correctness of the amount demanded.

11. This CREDIT will be cancelled in whole or in part upon receipt by us of a CERTIFICATE OF CANCELLATION, which (i) shall be in the form of Attachment B attached hereto, and (ii) shall be completed and signed by any person purporting to be an Authorized Representative, as defined in the next paragraph.

12. An "Authorized Representative" shall mean the following person: Executive Officer of the California State Board of Pharmacy

13. Communications with respect to this CREDIT shall be in writing and addressed to us at _____(Address of Financial Institution) specifically referring upon such writing to this CREDIT by number.

14. This CREDIT may not be transferred or assigned, either in whole or in part.

15. This CREDIT shall be deemed a contract made under the laws of the State of California.

16. This CREDIT shall, if not cancelled as provided herein, expire no later than _____ the date of its execution.

THEREFORE, _____ (Financial Institution) has executed and delivered this IRREVOCABLE STANDBY LETTER OF CREDIT to the Board as of the ___day of _____, 20__.

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

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

CERTIFICATE FOR DRAWING

Name of Financial Institution (ISSUER):_____

Address:_____

City, State, Zip:_____

Name of Applicant/Licensee:_____

Address:_____

City, State, Zip:_____

IRREVOCABLE STANDBY LETTER OF CREDIT NO. _____

Beneficiary:

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

The undersigned, a duly Authorized Representative of the California State Board of Pharmacy (Board) (as defined in the above referenced CREDIT), hereby certifies to the ISSUER that:

1. An Event of Default has occurred as defined in section 4 of the Agreement.

2. The undersigned is authorized under the terms of the above-referenced CREDIT to present this CERTIFICATE as the sole means of demanding payment on the CREDIT.

3. The Board is therefore making a drawing under the above-referenced CREDIT in the amount of $_____.

4. The amount demanded does not exceed the Principal Sum.

5. Sums received shall be used by the Board in accordance with the terms of the Agreement.

THEREFORE, the undersigned has executed and delivered this CERTIFICATE as of the ___day of _____, 20__.

CALIFORNIA STATE BOARD OF PHARMACY

By

PATRICIA HARRIS
Executive Officer

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

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

CERTIFICATE FOR CANCELLATION

Name of Financial Institution (ISSUER):_____

Address:_____

City, State Zip:_____

Name of Applicant/Licensee:_____

Address:_____

City, State Zip:_____

IRREVOCABLE STANDBY LETTER OF CREDIT NO. _____

Beneficiary:

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

The undersigned, a duly Authorized Representative of the California State Board of Pharmacy (Board) (as defined in the above referenced CREDIT), hereby certifies to the ISSUER that:

1. The license for which the credit was issued has expired or otherwise become inoperable, thereby making the cancellation of the credit appropriate.

2. The Board therefore requests the cancellation of the above-referenced CREDIT.

THEREFORE, the undersigned has executed and delivered this CANCELLATION as of the ___day of _____, 20__.

CALIFORNIA STATE BOARD OF PHARMACY

By

PATRICIA HARRIS
Executive Officer

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

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

CASH DEPOSIT IN LIEU OF BOND

I/We _____, hereinafter referred to as Assignor, whose
NAME OF APPLICANT/LICENSEE

principal place of business is located at _____, do/does hereby assign and set over to the California State Board of Pharmacy (Board), hereinafter referred to as Board, all right, title and interest of any kind whatsoever, owned or held by Assignor in the cash sum of _____dollars ($ _____) identified by Receipt Number _____, which is delivered to the Board pursuant to Section 4162 and/or Section 4162.5 of the Business and Professions Code and Section 995.710 of the Code of Civil Procedure. This assignment is binding on Assignor, his/her heirs, administrators, successors, and assigns, jointly or severally, and is conditioned that Assignor has made, or is about to make application to the Board for a license under Section 4162 and/or Section 4162.5 of the Business and Professions Code to act as a wholesaler or nonresident wholesaler.

Assignor understands that the Board is not authorized to refund said cash deposit until sixty (60) days beyond the date upon which an owner ceases to be licensed by the Board, or ceases to do business as a wholesaler.

Assignor further understands that the Board is authorized to reduce the sum of said cash deposit to the extent of all claims owing the California Board of Pharmacy arising from Assignor's business activities as a wholesaler and reasonable attorney fees and administrative costs incurred in processing claims against such cash deposit; that the reduction of such deposit by any amount shall be grounds for denial of a renewal of the wholesaler license until such time as the cash deposit is restored to its original amount under the provisions of Section 4162 and/or Section 4162.5 of the Business and Professions Code.

Executed in _____, on _____.
City and State Date

_____
Signature of Person Authorized to bind the business

_____
Printed or Typed name of Applicant/Licensee Exactly as shown above

_____
Type Name and Title of Person Authorized to bind the Business