California State Board of Pharmacy
2720 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833
Phone: (916) 518-3100 Fax: (916) 574-8618
www.pharmacy.ca.gov

Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

CHANGE OF PERMIT APPLICATION

(17A-52)

Includes Resident and Nonresident:

Wholesaler, Veterinary Food Animal Drug Retailer,
Third-Party Logistics Provider, Hypodermic Needles and Syringe

A Change of Permit Application must be submitted to the Board within 30 days when one of the following in Section A occurs within a license issued by the Board.

SECTION A **APPLICATION PROCESSING FEE:** Submit the appropriate application processing fee for EACH license affected by the change. If making changes that fall under 1 and 2, the fee is $130 for each license the changes affect. The application fee(s) is non-refundable.

Please mark all that apply and complete the corresponding sections throughout the application.

1. **$45 Application Processing Fee**
   - ☐ Address Change (not a physical change of location): Complete Sections B, C, D, and I
   - ☐ Tradestyle Name Change: Complete Sections B, C, E, and I
   - ☐ Corporate Name Change: Complete Sections B, C, F, and I
2. **$130 Application Processing Fee**
   - ☐ Officer(s)/Member(s)/Manager(s)/Partner(s)/Owner(s): Complete Sections B, C, G, I and J
   - ☐ Transfer an Assignment of Beneficial Interest: Complete Sections B, C, H, I, and J

SECTION B **LICENSEE INFORMATION** (Please Type or Print) *Complete a separate Change of Permit Application (17A-52) for EACH license affected by the change.*

1) _____ _____
Name of Licensee as it appears on the current License – may include DBA — License Type and Number

2) _____
Address of Licensee: Number and Street — City — State — Zip Code

3) _____ _____
Email Address of Licensee — Telephone Number

SECTION C **CONTACT PERSON AND AUTHORIZED SIGNER:** The Board will communicate deficiencies and status of application to the contact person via email. The Board will ONLY discuss the status of this application with the person identified as the contact person and any person who is listed on the license.

1) _____ _____ _____
Name of Contact Person — Telephone Number — Email Address

Board Use ONLY - Cashier #_____ Date _____ Amount _____
Date Processed: _____By _____ Date Approved:_____ By _____

A check box is provided next to each section to assist in providing the appropriate supporting documentation with the application. Failure to submit the supporting documentation may result in a delay in updating the license record which may impact your license renewal.

SECTION D **ADDRESS CHANGE (not a physical change of location):** This ONLY includes a change of street name or number made by the United States Postal Service (USPS), government entity, suite number, etc. *This does NOT include a physical change of location. A physical change of location requires a new license application.*

1) Submit one of the required supporting documentations:
   - ☐ A copy of the notice received from the USPS or Government entity reporting the change.
   - ☐ A copy of the lease agreement showing the new address.
   - ☐ Board minutes ratifying the address change.
   - ☐ Clear floor plans with documentation.

2) **Effective Date of Change** (*mm/dd/yyyy*) _____

3) _____
   New Address: Number and Street City State Zip Code

SECTION E **CHANGE OF TRADESTYLE NAME:** This does NOT include a change of ownership. *A change of ownership requires a new license application.*

1) Submit one of the required supporting documentations:
   - ☐ Fictitious name statement filed with the county. (In state facilities only)
   - ☐ Copy of home state license reflecting the name change. (Nonresident facilities only)
   - ☐ Copy of the board minutes ratifying the name change.
   - ☐ Other official document supporting the name change.

2) **Effective Date of Change** (*mm/dd/yyyy*) _____

3) _____
   New name of Licensee to appear on the License: may include DBA (Name cannot exceed 65 characters)

SECTION F **CHANGE OF CORPORATE NAME:** This does NOT include a change of ownership. *A change of ownership requires a new license application.* Reporting a corporate name change is required for any of the parent entities within the ownership tier of the licensee.

1) Submit one of the required supporting documentations:
   - ☐ Copy of the amended Articles of Incorporation/Organization or Certificate of Limited Partnership listing the new name.
   - ☐ Copy of the board minutes ratifying the name change

2) **Effective Date of Change** (*mm/dd/yyyy*) _____ **Check one:** ☐ Licensee Entity ☐ Parent Entity

3) _____
   Current Corporate Name

4) _____
   New Corporate Name

SECTION G NOTIFICATION TO ADD, REMOVE AND/OR TITLE CHANGE: OFFICER(S), PARTNER(S), MEMBER(S), MANAGER(S), OWNER(S).

1) Submit the required supporting documentation for each individual being added or removed from the license record.
   - ☐ Certificate of Personnel (17A-11): Submit a completed form for the new individual(s) being added.
   - ☐ Documentation verifying the added or removed individual(s). Documentation may include the following:
     - ☐ Statement of Information. Copy of the filing with the Secretary of State reflecting the officer change and bearing the Secretary of State stamp.
     - ☐ A copy of the board minutes reflecting the change.
     - ☐ Letter of resignation or memo reflecting the change. The documentation must also reflect the termination date
     - ☐ Letter of appointment or memo reflecting the change. The documentation must also reflect the effective date of the appointment of the individual into the position.
   - ☐ Fingerprints: Any new person being added to the license. Please reference Section J of the application instructions.

2) Please identify **ALL**: Owner(s), Corporation the officer(s); Partnership the partner(s); Limited Liability Company the member(s), manager(s), or officer(s). The type of change must be checked**.** If no change, check "No Change". *Use additional sheets, if necessary.*

Effective Date of Change (*Use exact date*)__________________ ☐Add ☐Delete ☐Change Title ☐No Change

____ _________________________

Full Legal Name List all Titles

____

Resident Address Number and Street City State Zip Code

Effective Date of Change (*Use exact date*)__________________ ☐Add ☐Delete ☐Change Title ☐No Change

____ _________________________

Full Legal Name List all Titles

____

Resident Address Number and Street City State Zip Code

Effective Date of Change (*Use exact date*)__________________ ☐Add ☐Delete ☐Change Title ☐No Change

____ _________________________

Full Legal Name List all Titles

____

Resident Address Number and Street City State Zip Code

Effective Date of Change (*Use exact date*)__________________ ☐Add ☐Delete ☐Change Title ☐No Change

____ _________________________

Full Legal Name List all Titles

____

Resident Address Number and Street City State Zip Code

SECTION H **TRANSFER AN ASSIGNEMENT OF BENEFICIAL INTEREST (ownership, stock, etc.)** Submit the required documentation below when the change to beneficial interest is within 10% to 49%, which does **NOT** result in the transferee holding 50% or more beneficial interest in the license in a single transaction or in a series of transactions, to any person or entity.

NOTE: Change of Ownership: *A transfer of beneficial interest in the facility licensed by the board, in a single transaction or in a series of transactions, to any person or entity, which transfer* ***results in*** *the transferee's holding* ***50% or more of the beneficial interest*** *in the licensed facility shall complete the appropriate licensing application and submit all required documents as instructed in a change of ownership application.* ***A change of ownership requires a new license application.*** *All approved change of ownership applications will result in a new license number being issued.*

1) Submit the required supporting documentation:
   - ☐ Personal Background Affidavit (17A-37): Submit a completed form for each NEW partner, member, and/or owner with original signature.
   - ☐ Organizational Chart: Submit an organizational chart defining the ownership structure before and after the change, including percentages owned by all parties.
   - ☐ Purchase Agreement/Documentation of Transfer: If the beneficial interest was acquired through a purchase agreement, submit a copy of the purchase agreement and documentation of the completed transaction.
   - ☐ Fingerprints: Any new person being added to the license. Please reference Section J of the application instructions.

2) Supporting Ownership Documentation:
   - ☐ Articles of Organization/Incorporation/Certificate of Limited Partnership
   - ☐ Statement of Information
   - ☐ Corporate Bylaws/Limited Liability Agreement/Partnership Agreement
   - ☐ Stock Certificates: Submit copies of currently issued stock certificates supporting the change. Please note: you may be asked to provide additional share holder information.
   - ☐ Stock Ledger: Submit documentation supporting the change of all current stock owners and shares owned by each person.
   - ☐ Indian Owned, if applicable: A copy of the constitution and bylaws establishing the tribal council that will be the governing entity of the licensed facility.

3) List the partner(s), member(s), or owner(s) with beneficial interest in the license along with the percentage of their current percentage of interest and/or new percentage of interest below. *Use additional sheets, if necessary.*

Effective Date of Change (*Use exact date*)_____ ____% of Interest Before ____% of Interest After

_____ _____
Full Legal Name Position Title(s)

_____
Resident Address Street City State Zip Code

Effective Date of Change (*Use exact date*)_____ ____% of Interest Before ____% of Interest After

_____ _____
Full Legal Name Position Title(s)

_____
Resident Address Street City State Zip Code

SECTION I Required Signature(s)

Any material misrepresentation provided to the Board is grounds for refusal or subsequent revocation of license, and a violation of the Penal Code of the State of California.

Under penalty of perjury, under the laws of the State of California, the person whose signature appears below, certifies and says:

1. Is the **owner, officer, director, manager, partner, member, or manager** of this license and is duly authorized to report these notifications on its behalf and is at least 18 years of age.
2. There have been no changes in officer(s), director(s), manager(s), partner(s), member(s), or owner(s) that have not been reported to the Board of Pharmacy and that each such officer, director, manager, partner, member, or owner listed is the real party in interest with respect to his/her position and is not acting directly or indirectly as an agent, employee or representative of any other person not reported to the board
3. Has read the foregoing application and knows the contents thereof and that each and all statements therein made are true.
4. 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; and
5. All supplemental statements are true and accurate.

Provide original signature. Scanned, stamped or an electronic signature may not be accepted.

_____	_____	_____
Original Signature	Printed Name	Date

SECTION J FINGERPRINTS (Not required if the license is government owned by the state, city or county.)

Each person who is required to complete a Certification of Personnel is required to complete the Live Scan or submit the Board approved fingerprint cards for a criminal background check with the Department of Justice (DOJ) and Federal Bureau of Investigation (FBI). If a person is currently associated with an active facility license and has electronic fingerprints on file with the California State Board of Pharmacy, new fingerprints may not be required. .

- **Officer:** Any New officer(s) listed on the application.
- **Director:** Any New director(s) listed on the application.
- **Partner:** Any New partner(s) listed on application.
- **Limited Liability Company:** Any New member(s) listed on application.
- **Manager:** Any New manager(s) listed on the application.
- **Owner:** Any New owner(s) listed on the application.

Fingerprint Instructions: Complete and attach **ONE** of the following (submit either 1 or 2)

- California residents must use Live Scan. Nonresidents can visit California to complete a Live Scan or must submit professionally rolled fingerprints on cards supplied by the board.
- DO NOT complete the Live Scan form prior to fingerprinting or fingerprint cards until the cards are ready to send with the application.
- The Live Scan site may charge a processing fee.
- Fingerprint card processing fee is $49 per person ($32 DOJ and $17 FBI) made payable to the Board of Pharmacy.
- The board will accept fingerprint responses only from the California Department of Justice (DOJ) and Federal Bureau of Investigation (FBI).

1. California Resident: Attach a copy of the completed Live Scan receipt. The receipt verifies the person has completed the Live Scan process and provides tracking information. It is the responsibility of the person being fingerprinted to verify that all his/her personal information entered by the Live Scan operator is correct prior to the operator's submission. The Board of Pharmacy will not accept clearances by the DOJ/FBI if the personal information is incorrect. Receipt of incorrect information by the DOJ/FBI will result in the individual having to complete a new Live Scan.

- California residents must use Live Scan only.
- To find a Live Scan location, go to https://oag.ca.gov/fingerprints/locations
- **Type of License/Certification/Permit or Working Title:** Pharmacy – Sect 4201
- **Full Name:** Must be EXACTLY THE SAME as the name on your state driver's license or state-issued identification card. (Jr., II, etc., must be included). It must also be EXACTLY THE SAME as the name on your application.
- **Date of Birth:** Must be correct.
- **Social Security Number (SSN) or Individual Taxpayer Identification Number (ITIN):** Include your SSN or ITIN number. If left blank you may have to reprint. If you have an ITIN, enter this number in the SSN field.
- **Level of Service:** Must include both DOJ and FBI.

2. Non-California Resident: The person being fingerprinted may visit California and complete Live Scan. If he/she cannot complete the Live Scan then two rolled fingerprint cards must be submitted to the board for each individual being fingerprinted.

- Only fingerprint cards provided by the Board of Pharmacy will be accepted.
- Request fingerprint cards through the board's online services at https://www.dca.ca.gov/webapps/pharmacy/pubs_request.php or via email to rxforms@dca.ca.gov.

- **Fee:** Include fingerprint card processing fee of $49 for each person ($32 DOJ and $17 FBI) made payable to the Board of Pharmacy. You may submit one check or money order for both the application processing fee and fingerprint processing fee(s).
- Print legibly or type personal information on the fingerprint cards. If the person's personal information is not legible and DOJ enters the information incorrectly, he/she will be responsible to submit new fingerprint cards and pay the $49 fingerprint processing fee again. DOJ will NOT correct print results due to illegible fingerprint cards.
- Fingerprints must be taken by a person professionally trained to roll fingerprints.
- Fingerprint clearances from cards take approximately six weeks.
- Poor quality prints will be rejected by DOJ/FBI and will cause delay because new fingerprint cards will be required.

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PERSONAL BACKGROUND AFFIDAVIT

This form is completed by each natural person listed on the application/license that has beneficial interest and/or management and control. A California licensed pharmacist, designated representative, designated representative-3PL, or a designated representative-reverser distributor does not need to complete this form unless listed as a natural person on the application. Failure to complete the form and provide the required information may result in the application being considered incomplete. Attach additional sheets of paper, if necessary.

Personal Information - Please Type or Print

_____ _____ _____
Full Legal Name - Last Name | First Name | Middle Name

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

_____
Residence Address - Street | City | State | Zip Code

_____ _____ _____
Telephone Numbers - Home | Cell | Work

_____ _____ _____
Email Address | **US Social Security Number or ITIN | Date of Birth (Month/Day/Year)

Applicant Business Information

_____ _____
Name of Applicant Business | Business Telephone Number

_____
Applicant Business Address - Street | City | State | Zip Code

Position with the Applicant Business is: (Check all that apply)

____ Owner ____ Partner ____ Officer ____ Stockholder ____ Member ____ Trustee
____ Government Representative ____ Professional Director ____ Administrator
____ Other, please specify the position _____

PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS (Attach additional sheets of paper if necessary)

1. Are you currently licensed as a physician, podiatrist, dentist, optometrist, or veterinarian in any state, territory, foreign country, or other jurisdiction, please provide the following information?
Yes ____ **No**____ If Yes, provide the following.

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

2. Is your spouse, child, parent, or other relative or any person with whom you share a financial interest is licensed in this state or any other state as a physician, podiatrist, dentist, or veterinarian, please list his or her name, relationship to you, the license type and number, and state? (Use additional sheets if necessary.)
Yes ____ **No**____ If Yes, provide the following.

Name	Relationship	License Type and Number	State
Name	Relationship	License Type and Number	State

3. Ownership Information

A. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator, or medical director on a license to conduct a pharmacy, wholesaler, third-party logistics provider, or any other entity licensed in any state, territory, foreign country, or other jurisdiction?
Yes ____ **No**____ If Yes, attach a statement of explanation including company name, type of license, license number, and identify the state, territory, foreign country, or other jurisdiction where licensed.

4. Disciplinary History

The following questions pertain to a license sought or held in any state, territory, foreign country, or other jurisdiction. For any affirmative answer, attach a statement of explanation including type of license, license number, type of action, date of action, and identify the state, territory, foreign country, or other jurisdiction.

A. Have you ever had an application for pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration denied?
Yes ____ **No**____

B. Have you ever had a pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration suspended, revoked, placed on probation, or had other disciplinary action taken against it?
Yes ____ **No**____

C. Have you ever had a pharmacy, wholesaler, third-party logistics provider, and/or any other entity license denied, suspended, revoked, placed on probation, or had other disciplinary action taken against a license you hold?
Yes ____ **No**____

5. Practice Impairment or Limitation

The board makes an individualized assessment of the nature, the severity, and the duration of the risks associated with any identified condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether the applicant is not qualified for licensure. If the board is unable to make a determination based on the information provided, the board may require an applicant to be examined by one or more physicians or psychologists, at the board's cost, to obtain an independent evaluation of whether the applicant is able to safely practice despite the mental illness or physical illness affecting competency. A copy of any independent evaluation would be provided to the applicant.

A. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice safely?
Yes ____ **No**____ If Yes, attach a statement of explanation.

B. Have you ever been diagnosed with a physical condition that may impair your ability to practice safely?
Yes ____ **No**____ If Yes, attach a statement of explanation.

C. Do you have any other condition that may in any way impair or limit your ability to practice safely?
Yes ____ **No**____ If Yes, attach a statement of explanation.

D. Have you ever participated in, been enrolled in, or required to enter into any drug, alcohol, or substance abuse recovery program or impaired practitioner program?
Yes ____ **No**____ If Yes, attach a statement of explanation.

E. If you answered "Yes" to questions listed under 5 (A through D) above, have you ever received treatment or participated in any program that improves your ability to practice safely?
Yes ____ **No**____ **N/A**____ If Yes, attach a statement of explanation.

APPLICANT AFFIDAVIT - Please read carefully and sign below.

Please provide a written explanation for all affirmative answers. Failure to provide any of the requested information may result in the application being deemed incomplete. Falsification of the information on this application may constitute grounds for denial or revocation of the license.

This information will be used to determine qualifications for licensure under California pharmacy law. The officer responsible for information maintenance is the Executive Officer at the California State Board of Pharmacy. This information may be transferred to another governmental agency, such as a law enforcement agency, if necessary to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by Civil Code section 1798.3.

****Disclosure of your U.S. Social Security number or individual taxpayer identification number (ITIN) is mandatory.** Business and Professions Code section 30, Family Code section 17520, and Public Law 94-455 (42 USC § 405(c)(2)(C)) authorize collection of your Social Security number or individual taxpayer identification number. Your Social Security number or individual taxpayer identification number will be used exclusively for

tax enforcement purposes; for purposes of compliance with any judgment or order for child or family support in accordance with section 17520 of the Family Law Code; or for verification of license or examination status by a licensing or examination entity that utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your Social Security number or individual taxpayer identification number, your application will not be processed and you may be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

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

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of all statements, answers, and representations made in the foregoing certification of personnel, including all supplementary statements; and that I personally completed this personal background affidavit. I understand that my application may be denied or any license disciplined for fraud or misrepresentation.

Provide original signature.

_____ _____

Signature (please sign and date within 60 days of filing the application) Date

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BUSINESS BACKGROUND AFFIDAVIT

This form is completed for the applicant business and signed by the owner, officer, member, or stockholder of that business. This form is also completed for any entity that owns the applicant business and signed by the authorized agent. The authorized agent must be authorized to act for and bind the company. All blanks must be completed; if not applicable enter "N/A.". Failure to complete the form and provide the required information may result in the application being considered incomplete. Attach additional sheets of paper, if necessary.

Please identify the business this form is being completed for:

A. Applicant Business ____
B. Owner/Parent ____

A. Applicant Information

_____
Name of Applicant Business

_____
Address of Applicant Business Street City State Zip Code

Position with the Applicant Business is: (Check all that apply)
____ Owner ____ Partner ____ Officer ____ Stockholder ____ Member
____ Government Representative ____ Administrator ____ Trustee
____ Other, please specify the position _____

B. Name of Owner

_____
Name of Parent Entity listed as Owner on Application

_____
Address Street City State Zip Code

_____ _____
Email Address Telephone Number

_____ _____
Name of Authorized Agent Telephone Number

Authorized Agent's position with this business is:
____ Owner ____ Executive Officer ____ Member ____ Manager ____ Principal ____ Other Specify _____

1. Is this business currently, or has it 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 Yes, provide the following information for each action taken, including licenses cancelled. (Use additional sheets if necessary)

State	Company Name	Type of License	License Number

Type of Action	Year of Action

2. Has this business ever been in violation of any provisions of California pharmacy law, including regulations?
Yes ____ **No**____ If "yes," list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.)

State	Company Name	Type of License	License Number

Type of Action	Year of Action

3. Has this business 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? This includes 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 1210.1 or 1203.4.
Yes ____ **No**____

Applicant Affidavit Please read carefully and sign below.

I hereby certify and affirm under penalty of perjury, under the laws of the State of California, that: (1) I am a person authorized to act for and bind the applicant and I am at least 18 years of age; (2) 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.

Original Signature	Date

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

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

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

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

Applicant Information:

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

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

Employer: This information is not required.

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

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

FINGERPRINTING AUTHORITY

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

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

DEPARTMENT OF JUSTICE

REQUEST FOR LIVE SCAN SERVICE

Print Form | Reset Form

Applicant Submission

A0071
ORI (Code assigned by DOJ)

License/Cert/Permit
Authorized Applicant Type

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

Contributing Agency Information:

Board of Pharmacy
Agency Authorized to Receive Criminal Record Information

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

2720 Gateway Oaks Drive, Suite 100
Street Address or P.O. Box

Licensing
Contact Name (mandatory for all school submissions)

Sacramento
City

CA
State

95833
ZIP Code

9165183100
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 BIL - Applicant Must Pay Fees
(Other Identification Number)

Home Address Street Address or P.O. Box

City | State | ZIP Code

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

Level of Service: ☒ DOJ ☒ FBI

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

Original ATI Number

Employer (Additional response for agencies specified by statute):

N/A
Employer Name

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

N/A
Street Address or P.O. Box

N/A
City

State

ZIP Code

N/A
Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency

LSID

ATI Number

Amount Collected/Billed

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