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

CLINIC LICENSE APPLICATION INSTRUCTIONS

The Board is authorized to issue clinic licenses as specified in sections 4180 and 4190 of the Business and Professions Code.

IMPORTANT: Please follow these instructions completely. Failure to submit the necessary items will delay the processing of your application. If the number of forms included in this application is insufficient, please make copies. Please allow approximately 45 days from the date your application is submitted before checking on the status. The contact person designated on the application will be advised if additional information is necessary.

A checklist is provided with these instructions. The Board encourages the submission of all required documentation with the application as well as the use of the checklist to assist with the application process. The Board may request additional documentation to confirm or substantiate information in the application. When submitting documents to the Board, please make a copy for your records.

SUMMARY OF CHECKLIST

Section A **Clinic Application and Processing Fee (All Applicants)**

Section B **Change of Ownership / Location**

Section C **Documentation Supporting Type of Clinic (All Applicants)**

Section D **Clinic Ownership Documents (All Applicants) -** Please refer to the respective ownership section (D1-D9) in the application instructions to identify the appropriate ownership documents to submit with the application.

D1 Individually Owned

D2 Partnership

D3 Corporation (Not Publicly Traded)

D4 Publicly Traded Corporation

D5 Limited Liability Company

D6 Trust

D7 Government Owned (state, city or county)

D8 - Indian Tribe Owned

D9 - Non-Native American owned but operating on tribal lands

Section E **Fingerprint Requirements**

CHECKLIST FOR FILING A CLINIC APPLICATION

Section A Clinic Application and Processing Fee (All Applicants)

All applicants are required to complete and submit the following:

1. **Clinic Application (17A-42):** Complete the entire application and submit with original signatures.
   - **Do Not Leave Blanks:** If an item or question is not applicable, indicate N/A.
   - **Doing Business As (DBA)**: If using a DBA, submit a completed Fictitious Business Name Statement that has been certified by the Office of the County Clerk in the county in which it was filed.

2. **Application Processing Fee is $570.**
   Include a check or money order made payable to the California State Board of Pharmacy. This fee is nonrefundable.

3. **Organizational Chart:** Provide a business ownership organizational chart that clearly documents the applicant business' ownership structure with the application. Include percentages owned by all parties and list the top five executive officers under the appropriate entity. If submitting a change of ownership application, include both the pre and post-closing organizational structures.

Section B Change of Ownership / Location

A clinic license is nontransferable. A license is issued to the owner(s) and for the location of the facility. All approved change of ownership and change of location applications will result in a new license number being issued. Operating the facility prior to a new license being issued is unlicensed activity and may result in denial or disciplinary action by the Board.

1. **Change of Ownership Documentation:** In addition to the application requirements in Sections A, C, D and E submit the following for a change of ownership application.
   - Seller's Certification (17A-8)
   - Copy of the signed proposed purchase agreement.
   - A copy of the final sale/closing documents will need to be submitted by the applicant applying for the clinic license prior to the issuance of the license.
   - Organizational Chart: Provide a business ownership organizational chart that clearly documents the applicant's business ownership structure with the application. Include both the pre- and post-closing business ownership structure.

Section C Documentation Supporting Type of Clinic (Submit items in C1 or C2)

C1 If the applicant is applying for a clinic license pursuant to Business and Professions Code section 4180, submit the following:

- **Department of Public Health (CDPH) License**: Submit a copy of the clinic's CDPH license or a statement on company letterhead citing the Health and Safety Code exception. The CDPH license must be current and contain the same name and address listed on the clinic application.

In addition to this application, if this clinic has submitted the Clinic Co-Location Application (17A-103) for Board approval to share a location with another clinic licensed by the Board, the following must be submitted with this application or at the time of submitting the clinic co-location application:

- **Documentation from the Director of the Department of Health Care Services:** Submit the items listed in A and B. These documents are required for the Board to complete the approval of a clinic co-location application.
  A. Provide documentation from the Director of the Department of Health Care Services that any Medi-Cal financing issues have been sufficiently addressed pursuant to subdivision (e) of section 4180.5 of the Business and Professions Code.
  B. Provide documentation from the Director of the Department of Health Care Services that any licensing and regulatory issues have been sufficiently addressed pursuant to subdivision (f) of section 4180.5 of the Business and Professions Code.

C2 If the applicant is applying for a clinic license pursuant to Business and Professions Code section 4190, submit the following:

- **Surgical Clinic**: Submit a copy of the clinic's CDPH license or a statement on company letterhead citing the Health and Safety Code exception. The CDPH license must be current and contain the same name and address listed on the clinic application.

- **Ambulatory Surgical Center**: Submit a current copy of the certification to participate in the Medicare Program or a copy of the approval letter from Medicare verifying the clinic is Medicare approved. The certificate or approval letter must list the name and address of the clinic.

- **Accredited Outpatient Setting:** Submit a copy of the accreditation certificate or a copy of the accreditation approval by an accreditation agency approved by the Medical Board of California. The accreditation certificate or approval letter must list the name and address of the clinic.

Section D Clinic Ownership Documents (All Applicants)

California Business and Professions Code section 4035 specifies "person" includes a firm, association, partnership, corporation, limited liability company, state governmental agency, trust, or political subdivision.

California Business and Professions Code section 4201(a) requires that "… the application shall state the information as to each person beneficially interested therein or any person with management or control over the license."

The application shall provide information to identify the ownership of the applicant business. The Board may require additional documentation to confirm or substantiate the reported ownership structure.

Provide ownership documents listed under the appropriate ownership type the applicant business.

D1 Individual Owner (Sole Proprietor) In addition to items listed in Sections A, C and E submit the following:

1. Certification of Personnel (17A-11):
   - Individual Owner
   - Professional Director
   - Administrator

D2 **Partnership** In addition to items listed in Sections A, C and E submit the following:

1. Certification of Personnel (17A-11):
   - Partner(s)
   - Executive officer(s)
     (If the applicant business does not hold executive officers, list the executive officers for the parent entity or the entity above the parent which holds the executive officers. The executive officer(s) must be identified by name and officer title on the organizational chart.)
   - Professional Director
   - Administrator

2. Business Background Affidavit (17A-18):
   - The applicant business
   - The parent entity(ies)

3. Partnership Agreement: Provide a copy of the current executed partnership agreement for the applicant business.

D3 **Corporation (Not Publicly Traded)** In addition to items listed in Sections A, C and E submit the following:

1. Certification of Personnel (17A-11):
   - Executive officer(s)
     (If the applicant business does not hold executive officers, list the executive officers for the parent entity or the entity above the parent which holds the executive officers. The executive officer(s) must be identified by name and officer title on the organizational chart.)
   - Professional Director
   - Administrator

2. Business Background Affidavit (17A-18):
   - The applicant business
   - The parent entity(ies)

3. Articles of Incorporation: Provide a copy of the Articles of Incorporation filed with the Secretary of State for the applicant business bearing the Secretary of State's stamp (proof of filing).

4. Statement of Information (a or b):
   a. Provide a copy of the current filing with the Secretary of State bearing the Secretary of State's stamp that discloses the current officers on file for the entity. For more information, go to http://www.sos.ca.gov/business/corp/pdf/so/corp_so350.pdf.

   OR

   b. Statement by Foreign Corporation **endorsed** by the California Secretary of State. *This is only required if the named corporation on the application is incorporated outside of California.*

5. Stock Certificates and Stock Ledger: Provide a copy of stock certificate(s) front and back along with a copy of the stock ledger, if stocks are issued. If stocks are not issued, please provide a statement that states as such signed by an officer listed on the application.

6. Bylaws: Provide a copy of the bylaws or internal operating rules for the applicant business.

D4 **Publicly Traded Corporation** In addition to items listed in Sections A, C and E submit the following:

1. Certification of Personnel (17A-11):
   - Executive officer(s)
     (If the applicant business does not hold executive officers, list the executive officers for the parent entity or the entity above the parent which holds the executive officers. The executive officer(s) must be identified by name and officer title on the organizational chart.)
   - Professional Director
   - Administrator

2. Business Background Affidavit (17A-18):
   - The applicant business
   - The parent entity(ies)

3. Corporation's 10K Filing: Provide a copy of the document filed with the Securities Exchange Commission.

D5 **Limited Liability Company** In addition to items listed in Sections A, C and E submit the following:

1. Certification of Personnel (17A-11):
   - Members
   - Executive officer(s)
     (If the applicant business does not hold executive officers, list the executive officers for the parent entity or the entity above the parent which holds the executive officers. The executive officer(s) must be identified by name and officer title on the organizational chart.)
   - Professional Director
   - Administrator

2. Business Background Affidavit (17A-18):
   - The applicant business
   - The parent entity(ies)

3. Articles of Organization: Provide a copy of the Articles of Organization filed with the Secretary of State for the applicant business.

4. Statement of Information (a or b):
   a. Provide a copy of the current filing with the Secretary of State bearing the Secretary of State's stamp that discloses the current officers on file for the entity. For more information, go to http://www.sos.ca.gov/business/corp/pdf/so/corp_so350.pdf

   OR

   b. Statement by Foreign Corporation **endorsed** by the California Secretary of State. *This is only required if the named corporation on the application is incorporated outside of California.*

5. Operating Agreement: Current business operating agreement for the applicant business.

D6 **Trust** In addition to items listed in Sections A, C and E submit the following:

1. Certification of Personnel (17A-11):
   - Trustee(s)
   - Professional Director
   - Administrator

2. Business Background Affidavit (17A-18):
   - The applicant business
   - The parent entity(ies)

3. Trust Document: Provide a copy of the trust or documentation signed under penalty of perjury by the authorized representative of the trust that lists the name(s) of the trustee(s) and beneficiaries, including the percentages of their interest in the trust.

D7 **Government Owned (City, State, or County) Clinic** In addition to items listed in Sections A, C, and E submit the following:

1. Certification of Personnel (17A-11):
   - Professional Director
   - Administrator

2. Letter of Verification: Printed on letterhead of the appropriate governing authority indicating that the facility is government owned.

D8 **Indian Owned** In addition to items listed in Sections A, C, and E submit the following:

1. Certification of Personnel (17A-11):
   - Tribal Council Member(s)
   - Professional Director
   - Administrator/CEO

2. Business Background Affidavit (17A-18):
   - The applicant business
   - The parent entity(ies)

3. U.S. Department of Interior, Bureau of Indian Affairs Official: Submit a copy of documents from the U.S. Department of Interior, Bureau of Indian Affairs, identifying the official tribe.

4. Constitution and By-laws: A copy of the constitution and by-laws establishing the tribal council that will be the governing entity of the clinic.

D9 **Non-Native American owned but operating on tribal lands** In addition to items listed in Sections A, C, and E submit the following:

If the non-Indian owner is a corporation provide the following:

1. Articles of Incorporation: A copy endorsed by the Indian tribe.

2. Statement by domestic stock: A copy endorsed by the Indian tribe.

3. **AND all other requirements** of a corporation listed in section D3, except the articles of incorporation and the statement by domestic stock must be endorsed by the Indian tribe and not by the Secretary of State.

If the non-Indian owner is a sole owner or partnership:

1. Agreement Documents: A copy of documents describing the agreements with the Indian tribe to operate the clinic on tribal land.

2. **AND all other requirements** of an individual owner or partnership listed in Section D1 or Section D2 respectively.

Section E Fingerprint Requirements

Each person who is required to complete a Certification of Personnel (as instructed in Section D) 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 clinic license and has electronic fingerprints already on file with the California State Board of Pharmacy, new fingerprints may not be required.*

ALL applicants including nonprofit organizations must complete the fingerprint requirement. (Government owned facilities are exempt from this requirement.)

Fingerprint Instructions: Complete and attach **ONE** of the following (either A or B):

- California residents must use Live Scan. Nonresidents can visit California to complete a Live Scan or submit fingerprints on cards supplied by the Board. The fingerprint cards must be processed at a location authorized to complete fingerprint cards for the DOJ/FBI (e.g. law enforcement agency) in the state the services are rendered.
- DO NOT complete the Live Scan service or fingerprint cards until the applicant is ready to send in 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).

A. California Resident: Attach a copy of the completed Live Scan receipt. The receipt verifies that the individual being fingerprinted has completed the Live Scan process and provides tracking information. It is the responsibility of the individual being fingerprinted to verify that all 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
- The individual being fingerprinted must ensure the following information is correct when completing the Live Scan:
  - **Type of License/Certification/Permit or Working Title:** Pharmacy Clinic– Section 4201
  - **Full Name:** Must be EXACTLY THE SAME as the individual's name on his/her state-issued driver's license or state-issued identification card (Jr., II, etc., must be included). It also must be EXACTLY THE SAME as the individual's name on the application.
  - **Date of Birth:** Do not omit. If left blank, he/she may have to reprint.
  - **Social Security Number (SSN):** If left blank, he/she may have to reprint.
  - **Level of Service:** Must include both DOJ and FBI.

B. Non-California Resident: The individual 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 with the application 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 individual being fingerprinted ($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 card processing fee(s).
- Print legibly or type personal information on the fingerprint cards. If the personal information of the individual being fingerprinted is not legible and DOJ enters the information incorrectly, he/she will be responsible to submit new fingerprint cards and pay the $49 fingerprint card processing fee again. DOJ will NOT correct print results due to illegible fingerprint cards.
- The fingerprint cards must be processed at a location authorized to complete fingerprint cards for the DOJ/FBI (e.g. law enforcement agency) in the state the services are rendered.
- 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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CLINIC LICENSE APPLICATION

1. **Applicant Information** (Name of Clinic cannot exceed 65 characters including spaces)

   A. _____
   Name of Clinic as it will appear on the License – may include DBA

   B. _____
   If different from above, list Legal Name of Clinic

   C. _____
   Address of Clinic Number and Street City State Zip Code

   D. _____ _____
   Clinic Email Address Clinic Telephone Number

2. **Type of Clinic** (Check one in either A or B)

   A. Identify the type of clinic pursuant to Business and Professions Code section 4180

   ☐ Nonprofit Community ☐ Free ☐ Operated by Community/Free ☐ Primary Care
   ☐ Nonprofit Multi-Specialty ☐ Student Health Center ☐ Operated by Indian Tribe/Organization

   B. Identify the type of clinic pursuant to Business and Professions Code section 4190

   ☐ Surgical Clinic
   ☐ Ambulatory Surgical Center. Is the clinic Medicare Certified? If yes, attach a copy of the current Medicare certificate. ☐ Yes ☐ No
   ☐ Accredited Outpatient Setting. Is the outpatient setting accredited by an accreditation agency approved by the Medical Board of California? If yes, attach a copy of the certificate. ☐ Yes ☐ No

3. **Type of Application**

   ☐ New Clinic _____ Anticipated Opening Date
   ☐ Change of Ownership _____ Anticipated Change of Ownership Date
   ☐ Change of Location: _____ Anticipated Move Date

4. **Type of Ownership** (check one)

   ☐ Individual ☐ Partnership ☐ Limited Liability Company ☐ Trust
   ☐ Corporation (Not publicly traded) ☐ Nonprofit Corporation ☐ Publicly Traded
   ☐ Government ☐ NonNative Owned ☐ Indian Owned

   Provide the FEIN # (Federal Employer ID #) _____ - _____

For Board Use ONLY Date Cashiered: _____
Date Processed: _____ Date Issued: _____ Cashiering #: _____
Processed by: _____ Issued by: _____ Amount Received: _____

5. **Change of Ownership or Location** Provide the exact name, address, location, and license number as listed on the current clinic license.

_____ _____

Name listed on the Current Clinic License | License Number

_____

Address: Number and Street | City | State | Zip Code

_____ _____

Expiration Date of License | Effective Date of Change of Ownership/Location

6. **Ownership Information**

California Business and Professions Code section 4035 specifies “person" includes firm, association, partnership, corporation, limited liability company, state governmental agency, trust, or political subdivision. The application shall provide information to identify the ownership of the applicant business. This may include a parent company as well as each officer, partner and member (as appropriate) for the applicant business.

- Provide an organizational chart that clearly documents the applicant business’ ownership structure, including percentages owned by all parties.
- Complete and submit a Business Background Affidavit (17A-18) for an entity listed under this section signed by its authorized agent.

The Board may require additional documentation to confirm or substantiate the reported ownership structure at any time during the application process.

Entities:

If the applicant business is owned by an entity (not a natural person), identify each parent entity that has beneficial interest and has management and control of the applicant business, and identify its authorized agent. The authorized agent shall be an officer, partner, member, owner, or trustee of the parent business who is authorized to bind the business. Use additional sheets, if necessary.

A. _____ _____

Partnership - Name of Partner 1 | % Owned

_____ _____

Name of Authorized Agent | Telephone Number

_____ _____

Partnership – Name of Partner 2 | % Owned

_____ _____

Name of Authorized Agent | Telephone Number

B _____ _____

Name of Corporation | % Owned

_____ _____

Name of Authorized Agent | Telephone Number

C. _____ _____

Name of Limited Liability Company % Owned

_____ _____

Name of Authorized Agent Telephone Number

D. _____ _____

Name of Government Agency or Trust % Owned

_____ _____

Name of Authorized Agent Telephone Number

E. _____ _____

Name of Indian Tribe Owned or Non-Native American Owned % Owned

_____ _____

Name of Authorized Agent Telephone Number

7. <u>Natural Person(s):</u> LIST ALL TITLES, IF SERVING IN MORE THAN ONE CAPACITY.

Provide the Top 5 name(s) of each owner, partner, member, manager, stockholder, trustee, or administrator (government owned) who is a natural person of the applicant business. If there are no natural person(s) under the applicant business, list the owner(s), partner(s), member(s), manager(s) stockholder(s), trustee(s), administrator (government owned), or tribal council member(s) who are natural persons for the parent business as listed in the Entities section. Natural persons identified shall be authorized to act for and bind the applicant business.

_____ _____ _____

Position Title(s) Full Legal Name % of Ownership

_____ _____ _____

Position Title(s) Full Legal Name % of Ownership

_____ _____ _____

Position Title(s) Full Legal Name % of Ownership

_____ _____ _____

Position Title(s) Full Legal Name % of Ownership

_____ _____ _____

Position Title(s) Full Legal Name % of Ownership

_____ _____ _____

Position Title(s) Full Legal Name % of Ownership

_____ _____ _____

Position Title(s) Full Legal Name % of Ownership

8. Executive Officer(s) Information LIST ALL TITLES, IF SERVING IN MORE THAN ONE CAPACITY.

Provide the Top 5 name(s) of the top five executive officer(s) for the applicant business. If there are no officers of the applicant business, list the top five officer(s) for the parent business as listed in the Entities section.

Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership
Position Title(s)	Full Legal Name	% of Ownership

9. List the Professional Director, Administrator, and Consulting Pharmacist of the Clinic

The Board is authorized to issue clinic licenses pursuant to sections 4180 and 4190 of the Business and Professions Code. A clinic applying under section 4180 of the Business and Professions Code must comply with the requirements as defined in Chapter 9, Division 2, Article 13. A clinic applying under section 4190 of the Business and Professions Code must comply with Chapter 9, Division 2, Article 14.

The policies and procedures to implement the laws and regulations shall be developed and approved by the professional director, the clinic administrator, and the consulting pharmacist.

Name of Professional Director	License Type and Number
Name of Administrator	License Type and Number
Name of Consulting Pharmacist	License Type and Number

Professional Director Certification: I certify as the Professional Director of this clinic, I shall comply with the requirements as defined in Pharmacy Law.

Signature of Professional Director	Date

Administrator Certification: I certify as the Administrator of this clinic, I shall comply with the requirements as defined in Pharmacy Law.

Signature of Administrator	Date

Consulting Pharmacist Certification: I certify as the Consulting Pharmacist for this clinic, I will comply with the requirements as defined in Pharmacy Law. I further certify that the policies and procedures of the clinic's drug distribution service, relative to inventories, security procedures, training, protocol development, recordkeeping, packaging, labeling, dispensing, and patient consultation are consistent with the promotion and protection of the health and safety of the public.

_____ _____

Signature of Consulting Pharmacist Date

10. Contact Person: The Board will ONLY discuss the status of this application with the person identified as the contact person and any person who has signed the application as an officer, partner, member, and/or owner of the applicant business. An authorized owner may designate additional individuals to receive information on this pending application by submitting the Authorization to Release Applicant Information form. The Board will communicate deficiencies and status of application to the contact person via email.

_____ _____ _____

Name of Contact Person Telephone Number Email Address

11. APPLICANT AFFIDAVIT - Read carefully and sign below.

This application must be approved by the California State Board of Pharmacy before a clinic license will be issued. The applicant a clinic shall not conduct business in California until a license is issued. If changes are made during the application process, the applicant may need to submit a new application with appropriate fees**. Any application not completed within 60 days after being notified by the Board of deficiencies may be deemed to have been abandoned, and the applicant may be required to file a new application and meet all the requirements that are in effect at the time of application. Fees applied to this application are not transferable or refundable.**

Failure to provide any of the requested information may result in the application being considered incomplete. Any material misrepresentation in the answer of any question is grounds for denial or subsequent revocation of the license and is a violation of the California Penal Code. 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 at the California State Board of Pharmacy. The 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 California State Board of Pharmacy, unless the records are identified as confidential and exempted by Civil Code section 1798.38.

NOTICE: 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.

ALL OWNERS AND OFFICERS SIGN BELOW: This includes the authorized agent for the entity ownership as well as the individual owner, partners, executive officer(s), member(s), manager(s), trustee(s), administrator (government owned), and tribal council member(s) who are authorized to bind the applicant business listed on the application.

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

Is the **owner, partner, member, manager, officer, trustee, director, administrator (government owned), or tribal council member(s)** of the applicant business named in the foregoing application, duly authorized to make this application on its behalf and is at least 18 years of age;

1) Has read the foregoing application and knows the contents thereof and attests to the truth and accuracy of all statements, answers, and representations made in this application, including all supplementary statements.;
2) No person other than the applicant or applicants has any direct or indirect interest or management and control in the applicant clinic to be conducted under the license for which this application is made;
3) Understands that falsification of any information in this application may constitute grounds for denial or subsequent revocation of the license; and
4) A change of ownership application may be withdrawn by either the applicant or the licensee with no resulting liability to the California State Board of Pharmacy.

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

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

AUTHORIZATION TO RELEASE APPLICANT INFORMATION

(Optional)

Applicant Business Information – Please print or type File Number, if applicable _____

_____ _____

Name of Business Telephone Number of Business

_____

Name of Business DBA if different than above

_____

Address of Business – Street City State Zip Code

The Board will ONLY discuss the status of this application with the authorized person identified on the application and any person who has signed the application as an officer, partner, member, and/or owner of the applicant business. In order for the Board to discuss the status of this application with another individual, the authorized person identified on the application must authorize in writing the Board to discuss the application status with a his or her authorized representative.

Giving consent for the Board to disclose application and business information will authorize the Board to disclose all personal and business information pertaining to this application. This includes but is not limited to social security number, date of birth, address information, all application requirement information, application approval or denial status, and any criminal conviction information the Board may have on record for your application.

Applicant Consent – Must be signed and dated by the applicant for optional authorization to be valid.
As a person identified on the application that is authorized to act for and bind the applicant business, I hereby give the Board consent to communicate to the individual listed below.

I, _____, hereby give consent to
Print Name of Person Authorized to Bind the Applicant Business

the California State Board of Pharmacy to disclose information about this application as specified above to the following individual:

_____ _____ _____

Name Telephone Number Email Address

_____

Mailing Address – Street City State Zip Code

This consent will expire on _____ , within one year, or upon licensure, whichever comes first. (Date)

_____ _____

Original Signature of Person Authorized to Bind the Applicant Business Date

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CERTIFICATION OF PERSONNEL

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 only acting as the pharmacist-in-charge/consulting pharmacist 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.

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

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

(b) You may not order a pharmacist to perform any act that is prohibited by law.
Any violation of the Federal Food, Drug & Cosmetic Act, the Federal Controlled Substance Act or any law or regulation relating to the practice of pharmacy in the State of California is grounds for suspension or revocation of the permit for which you are applying.

(c) Any violation of the Federal Food, Drug & Cosmetic Act, the Federal Controlled Substance Act or any law or regulation relating to the practice of pharmacy in the State of California is grounds for suspension or revocation of the permit for which you are applying
(d) Committing any act prohibited by law or neglecting to perform any duty required by law could result in proceedings against the personal license of a pharmacist or could result in an action against your permit.
(e) You are not permitted to assist in any phase of compounding or dispensing of prescriptions, or to perform any of the duties that are required by law or regulation to be done by a pharmacist.
(f) Only a pharmacist may possess the key to the pharmacy or to the permanent barrier separating the pharmacy.
(g) You may enter the pharmacy for the purpose of performing certain specified duties only when the pharmacist is present; and the pharmacist is responsible for any non-registered person allowed to enter the pharmacy. (This does not apply to hospital pharmacies or limited permits under Business and Professions Code section 4117, or Title 16, California Code of Regulations section 1714).
(h) Dangerous drugs and/or devices as defined in Business and Professions Code sections 4022 and 4023 may only be sold by prescription or to persons who are licensed to handle, sell and possess such drugs.

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

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

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 and submit separate forms for the applicant and the parent 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 Application File # if known

_____
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 FEIN #

_____
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

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

SELLER'S CERTIFICATION

INSTRUCTIONS: This form is to be completed by the seller and submitted with the application for a change of ownership by the prospective owner. A copy of the pending purchase agreement must be attached. Please print or type.

NOTICE: The license is not transferable, and the current owner of record must maintain operations and control of the licensed premises (including renewing the license) until the change of ownership is approved by the California State Board of Pharmacy. Proof of authority to sell by any person, other than a person whose name appears on the California State Board of Pharmacy license record, must accompany this certification.

This will certify that _____
Name of Seller

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

of the right, title and interest in _____ _____
Name of Facility License Number

Located at _____
Address City State Zip Code

List the Name of all Buyer(s)

_____ _____

_____ _____

On completion of this sale and approval of the new license, the original license, and the current renewal must be returned to the California State Board of Pharmacy.

Under penalty of perjury under the laws of the State of California, each person whose signature appears below certifies and says that (If the seller is a partnership, all partners must sign below):

1. Is the licensee, named in this Seller's Certification, duly authorized to make this sale;
2. Is listed on the current license; and
3. All statements made in this Seller's Certification are true and correct.

_____	_____	_____	_____
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 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

Phy Clinic - Section 4201
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