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

APPLICATION FOR CHANGE OF DESIGNATED REPRESENTATIVE-IN-CHARGE (DRIC)

A wholesaler (including a nonresident wholesaler or a veterinary food-animal drug retailer) is required to notify the board within 30 days of the date when a DRIC ceases to act as the DRIC and is further required to propose another licensee to take over as DRIC. Failure to make this notification to the board may result in a citation and fine or disciplinary action. The proposed DRIC shall be subject to approval by the board. If disapproved, the wholesaler shall propose another replacement within 15 days of the date of disapproval.

INSTRUCTIONS: Submit an *Application for Change of DRIC* form and the **$250** application fee. Make checks payable to the Board of Pharmacy. Important: List the license number for the facility and the DRIC. A Certification of Personnel form, fingerprint cards, and the $49 fingerprint card processing fee is required by the proposed new DRIC ONLY if licensed as a pharmacist in another state.

1. Licensed Facility Location - Type or Print in Blue or Black Ink

Name of Facility _____ Facility License _____
Address of Facility _____
City _____State _____ Zip Code _____
Facility's Telephone Number _____ Email Address _____
Contact Name:_____ Email Address _____

2. Proposed New DRIC – Must be a registered pharmacist or a designated representative who is currently licensed.

_____ _____
Name of Proposed New DRIC License Number

Effective Date of Change (Month/Day/Year) _____Email Address _____

3. DRIC being REPLACED

_____ _____
Name of Prior DRIC License Number

End Date (Month/Day/Year) _____Telephone Number _____Email:_____

4. ***I certify that all statements, answers, and representations made on this form are true and correct.***

_____
Original Signature of Corporate Officer, Partner, Owner or Member | Print Name | Title | Date

_____ _____
Original Signature of Proposed New DRIC Date | Signature of replaced DRIC (If available) Date

17A-E1 (rev 10/2024)
Board Use ONLY - Cashier #_____ Date _____ Amount _____
DRIC: DOJ/FBI _____ Date Processed:_____ By: _____ Comments:_____

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CERTIFICATION OF PERSONNEL

1. Personal Information - Type or Print in Blue or Black Ink

Legal Last Name | Legal First Name | Middle Name

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

Address - Street | City | State | Zip Code

Personal Telephone Number | Work Telephone Number | Email Address

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

2. Licensee Information

Facility Name | License #

3. Ownership Information

Do you or have you had any direct or indirect beneficial interest in, or do you or have you exercised management and control over and/or served as an officer, director, manager, member, partner, stockholder, trustee, professional director, or administrator for, a pharmacy, clinic, wholesaler, third-party logistics provider, or outsourcing facility licensed in California or any other state, jurisdiction, territory, or country?

Yes ☐ No ☐ If Yes, list all current and past licenses. Attach additional sheets if necessary.

Name of Facility	License Type and Number	State Issued

4. Disciplinary History

The following questions pertain to a license sought or held in California or any other state, jurisdiction, territory, or country. 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, jurisdiction, territory, or country.

A. Have you ever had an application for any professional or vocational license or registration denied or any professional or vocational license or registration suspended, revoked, placed on probation, or had other disciplinary action taken against it?
Yes ☐ No ☐ If Yes, provide a signed and dated statement of explanation.

B. Have you ever had a pharmacy, clinic, wholesaler, third-party logistics provider, outsourcing facility and/or any other facility license denied, suspended, revoked, placed on probation, or had other disciplinary action taken against a license you hold?
Yes ☐ No ☐ If Yes, provide a signed and dated statement of explanation

A signature is required, and must be an original dated signature or a digital signature that complies with the Board's Digital Signatures Policy Statement located on the Board's website. All documents with digital signatures shall be emailed to the Board.

I hereby certify that all statements, answers, and representations made in the foregoing Certification of Personnel form are true and correct.

_____ _____

Signature of individual completing this form Date