



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 NOTIFICATION

APPLICATION FOR CHANGE IN PROFESSIONAL DIRECTOR

California law requires licensed clinics to notify the California State Board of Pharmacy, on a form furnished by the Board, within 30 days of any change in Professional Director. Failure to make this notification to the Board may result in a citation and fine or disciplinary action.

INSTRUCTIONS: Submit a completed *Clinic License Notification: Application for Change in Professional Director* form, the **\$250** application fee, and a *Certification of Personnel* form. Make the check payable to the Board of Pharmacy. A copy of a completed Live Scan form is required by the new Professional Director **ONLY** if they are not currently associated with an active clinic license and does not have has electronic fingerprints on file with the Board of Pharmacy.

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. New Professional Director

Name _____ License Number _____
Effective Start Date of New Professional Director (Month/Day/Year) _____

3. Professional Director being REPLACED

Name _____ License Number _____
End Date as Professional Director (Month/Day/Year) _____

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 New Professional Director Date

17A-112 (10/2024) Board Use ONLY - Cashier # _____ Date _____ Amount _____
PD: FP _____ Date Processed: _____ By _____ Comments _____



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



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