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

CORRECTIONAL CLINIC LICENSE APPLICATION INSTRUCTIONS

The board is authorized to issue a correctional clinic license pursuant to sections 4187 of the Business and Professions Code. Clinics applying under section 4187 of the Business and Professions Code must comply with the requirements as defined in Chapter 9, Division 2, Article 13.5.

A correctional clinic is a primary care clinic owned or operated by the state to provide health care to eligible patients of the California Department of Corrections and Rehabilitation (CDCR). [Health & Safety Code section 1206(b)]

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 **Correctional Clinic Application and Processing Fee (All Applicants)**

Section B **Change of Ownership / Location**

Section C **Government Owned Correctional Clinic**

Section D **All Other Types of Ownership -** Please refer to the respective ownership section (D1-D5) in the application instructions to identify the appropriate ownership documents to submit with the application.

D1 Individually Owned

D2 Partnership

D3 Corporation

D4 Limited Liability Company

D5 Trust

Section E **Fingerprint Requirements (All Applicants)**

CHECKLIST FOR FILING A CORRECTIONAL CLINIC APPLICATION

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

All applicants are required to complete and submit the following:

1. **The application fee is $620.**
   Include a check or money order made payable to the California State Board of Pharmacy. This fee is nonrefundable.

2. **Correctional Clinic Application (17A-108):** Complete the entire application and submit with original signatures.

3. **Certification of Personnel (17A-11):** The Chief Executive Officer, highest ranking health care administrator at the correctional institution for which the application is for, needs to complete and submit a Certification of Personnel (17A-11).

4. **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.

5. **Acknowledgement Affidavit:** A signed acknowledgement by the correctional facility pharmacist-in-charge servicing the applicant institution, the pharmacist-in-charge for the California Department of Correction and Rehabilitation's Central Fill Pharmacy, and the correctional clinic's chief medical executive, supervising dentist, chief nurse executive, and chief executive officer verifying that the policies and procedures to implement the laws and regulations within a correctional clinic have been developed and approved by the statewide Correctional Pharmacy and Therapeutics Committee referenced in Section 5024.2 of the Penal Code.

Section B Change of Ownership / Location

A correctional 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.
   - 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 Government Owned Correctional Clinic Documents

In addition to items listed in Sections A submit the following:

1. A letter of verification from the Chief Executive Officer indicating that the institution is government owned and operated.

Section D All other Types of Ownership Documents

In addition to items listed under the specific type of ownership, submit a copy of the contractual agreement between the State and the Owner of the correctional institution for the State to Operate a Correctional Clinic.

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

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

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

1. Certification of Personnel (17A-11):
   - Top 5 Partner(s)

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

D3 Corporation In addition to items listed in Sections A and E submit the following:

1. Certification of Personnel (17A-11):
   - Top 5 Executive officer(s)

2. 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).

3. Statement of Information: 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.

D4 Limited Liability Company In addition to items listed in Sections A and E submit the following:

1. Certification of Personnel (17A-11):
   - Top 5 Members
   - Top 5 Executive officer(s)

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

3. Statement of Information: 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.

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

D5 **Trust** In addition to items listed in Sections A and E submit the following:

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

2. 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.

Section E Fingerprint Requirements (All Applicants)

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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CORRECTIONAL CLINIC LICENSE APPLICATION

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The board is authorized to issue a correctional clinic license pursuant to sections 4187 of the Business and Professions Code. Clinics applying under section 4187 of the Business and Professions Code must comply with the requirements as defined in Chapter 9, Division 2, Article 13.5.

APPLICATION FEE: $620: Include a check or money order made payable to the California State Board of Pharmacy. This fee is nonrefundable.

1. **APPLICANT INFORMATION** (The license will list the name of the Correctional Institution and the name of the Clinic - cannot exceed 65 characters including spaces)

   A. _____
   Clinic Name to Appear on the License

   _____
   Location of Clinic (Area, Building, Room Name/Number)

   B. _____
   Name of Correctional Institution Telephone Number

   C. _____
   Name of Licensed Correctional Pharmacy License Number

2. **TYPE OF CLINIC** ☐ Dental ☐ Medical ☐ Other, identify _____

3. **TYPE OF APPLICATION**

   ☐ New Clinic _____ Anticipated Opening Date

   ☐ Change of Location: _____ Anticipated Move Date

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

4. **CHANGE OF LOCATION: Provide the exact name, address, location, and license number** as listed on the current Clinic license. This license will be canceled upon issuance of the new Correctional Clinic license.

Name of Current Clinic | CLE License Number

5. **CONTACT PERSON:** The Board will ONLY discuss the status of this application with the individuals identified as the contact person, Pharmacist-in-Charge, and Chief Executive Officer. The Board will communicate deficiencies and status of application to the contact person(s) via email.

Name of Contact Person | Telephone Number | Email Address

Name of Contact Person | Telephone Number | Email Address

6. **NAME OF LICENSED CORRECTIONAL PHARMACY'S PHARMACIST-IN-CHARGE (PIC)**

The PIC of the correctional pharmacy shall implement the policies and procedures developed and approved by the statewide Correctional Pharmacy and Therapeutics Committee referenced in Section 5024.2 of the Penal Code and the statewide Inmate Medical Services Policies and Procedures in conjunction with the chief executive officer, the chief medical executive, the supervising dentist, and the chief nurse executive.

PIC CERTIFICATION: I certify that I have read and reviewed this application and shall comply as defined in Pharmacy Law.

Name of PIC | License Number

PIC Email Address | Telephone Number

Signature of PIC | Date

7. **CHIEF EXECUTIVE OFFICER:** Submit a letter of from the Chief Executive Officer indicating that the institution is government owned and operated.

Name of the Chief Executive Officer

8. APPLICANT AFFIDAVIT - Read carefully and sign below.

This application must be approved by the California State Board of Pharmacy before a correctional clinic license will be issued. Failure to complete the application within 60 days after being notified by the board of deficiencies the applicant may be deemed to have abandoned the application and may be required to file a new application and meet all the requirements in effect at the time of reapplication pursuant to Title 16, California Code of Regulations section 1706.2(a).

Failure to provide any of the requested information may result in the application being deemed incomplete. Any material misrepresentation in the answer of any question is grounds for denial or subsequent revocation of license, and is a violation of the California Penal Code. All items of information requested in this application are mandatory as defined in Chapter 9, Division 2, Article 13.5.

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 as the board's address. The information may be transferred to another governmental agency, such as a law enforcement agency, if necessary, for it to perform its duties. Each person 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 section 1798.38 of the Civil Code.

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.

Under the laws of the State of California, the person whose signature appears below certifies that:

1) Is the **Chief Executive Officer** of the correctional clinic named in the foregoing application, duly authorized to make this application on its behalf and is at least 18 years of age;
2) 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.
3) They understand that falsification of any information in this application may constitute grounds for denial or subsequent revocation of the license.

_____

Signature Chief Executive Officer 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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CORRECTIONAL CLINIC ACKNOWLEDGMENT AFFIDAVIT

Please complete this form. The form is provided to help the correctional clinic applicant to demonstrate compliance with Business and Professions Code section 4187, subdivision (a) that states:

> *"The policies and procedures to implement the laws and regulations of this article within a correctional clinic shall be developed and approved by the statewide Correctional Pharmacy and Therapeutics Committee referenced in Section 5024.2 of the Penal Code. Prior to the issuance of a correctional clinic license by the board, an acknowledgment shall be signed by the correctional facility pharmacist-in-charge servicing that institution, the pharmacist-in-charge for the California Department of Correction and Rehabilitation's Central Fill Pharmacy, and the correctional clinic's chief medical executive, supervising dentist, chief nurse executive, and chief executive officer."*

By signing this acknowledgement, you are affirming that you fully understand the foregoing and the correctional clinic is in compliance with Business and Professions Code section 4187, subdivision (a).

Signature of Correctional Facility Pharmacist-in-Charge Servicing the Institution	Printed Name	Date
Signature of Pharmacist-in-Charge for the California Department of Correction and Rehabilitation's Central Fill Pharmacy	Printed Name	Date
Signature of Correctional Clinic's Chief Executive Officer	Printed Name	Date
Signature of Correctional Clinic's Chief Medical Executive	Printed Name	Date
Signature of Correctional Clinic's Supervising Dentist	Printed Name	Date
Signature of Correctional Clinic's Chief Nurse Executive	Printed Name	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 THE FOLLOWING QUESTIONS (Attach additional sheets of paper if necessary)

1. If you are currently licensed as a physician, podiatrist, dentist, optometrist, or veterinarian in any state, territory, foreign country, or other jurisdiction, please provide the following information.

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. If 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.)

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