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

DESIGNATED REPRESENTATIVE APPLICATION INSTRUCTIONS

A person applying for a designated representative license must demonstrate he/she meets the requirements for licensure pursuant to Business and Professions Code section 4053.

HOW LONG WILL IT TAKE TO PROCESS MY APPLICATION?

- Allow the Board 30 days to process your application.
- You will be notified in writing if your application is incomplete.
- Please do not contact the Board to check on the status of your application unless your application has been on file for over 45 days.
- If your check has cleared your bank, the Board has received your application.
- Once you have completed all the requirements for licensure and the Board has approved the issuance of your license, you will receive an email notifying you of the issuance of your license. In addition, you may verify your license at www.pharmacy.ca.gov. Select "Verify a License" and enter your name. Please allow four to six weeks from the date a license is issued to receive the license in the mail.

WHAT MAKES AN APPLICATION COMPLETE

Please review 1-10 to ensure your application is complete before mailing it to the Board.

- If your application is not complete, you will receive a "Deficiency Notice" via email.
- You will not be issued a license until the Board receives and approves the required item(s) identified in your deficiency notice.
- Failure to complete your application within 60 days from the date the Board notifies you of the deficiencies, may result in your application being considered abandoned and withdrawn.

1. **APPLICATION FEE IS $210:**
   When you send your application, include a check or money order made payable to the California State Board of Pharmacy. The application fee is non-refundable.

2. **APPLICATION FOR A DESIGNATED REPRESENTATIVE LICENSE** (form 17A-E): Complete the entire application. It is preferable to complete the application online, print, then sign (wet signature) and date the application. To facilitate electronic communication, please provide an email address.

   AVOID COMMON MISTAKES

   - **Look at your state issued driver's license or state issued identification card prior to completing the application.** The name on each form listed below must be **EXACTLY THE SAME** as the name on your state issued driver's license or state issued identification card. If you have a hyphenated name, two last names, or two first names, you need to list your name on each of the following documents to match that of your state issued identification:
     - ✓ Designated Representative Application,
     - ✓ Request for Live Scan form or fingerprint cards, and
     - ✓ Self-Query Report.

- Have you ever used a different name? List each prior name on the application under Previous Names.
  - ✓ Did you have a maiden name, married name, former name, AKA?
  - ✓ Have you ever used Jr., Sr., II, etc., with your name?
  - ✓ If you do not list all of your previous names, the Board may not locate, match or verify your documents.
  - ✓ Do you have a pharmacy technician license issued in another name? If yes, submit a copy of your state issued identification for the Board to update your name.
- Do not leave anything blank; use "N/A" if a question doesn't apply to you.
- Do not let your employer or school fill out your application.
- Sign and date the application within 60 days of filing the application. No one else can sign the application for you. Electronic, stamped, copies or faxed signatures or signatures that do not meet the above requirements may result in an incomplete application.

3. **U.S. SOCIAL SECURITY NUMBER OR INDIVIDUAL TAXPAYER IDENTIFICATION NUMBER (ITIN):** You are required to disclose your U.S. social security number or Individual Taxpayer Identification Number (ITIN). It must be included on the application.

4. **PHOTO:** Attach a passport-style photo to page 1 of the application (2"x2" glossy, colored photo) taken within 60 days of filing the application. **DO NOT** provide scanned images, Polaroids, or black-and-white photos.

5. **MILITARY EXPEDITE:** The Board will expedite review of an application that meets one of the following criteria (A, B, or C).

   A. Serving in the Military: Are you currently serving in the United States military?

      ✓ Attach a copy of your military identification.

   B. Military Veteran: Have you ever served in the United States military?

      ✓ Please attach a copy of your DD214 with your application.

   C. Active Duty Military-Spouses or Partners: If your spouse or partner is an active duty member of the U.S. Armed Forces and you hold a current license in another state, please provide the following:

      ✓ A copy of your current license in another state, district, or territory of the United States documenting the profession or vocation for which you seek licensure from the Board.
      ✓ A copy of the marriage certificate, certified declaration/registration of domestic partnership, or other evidence of legal union.
      ✓ A copy of your spouse or partner's military orders establishing duty station in California.

6. **MANDATORY EDUCATION**: You must be a high school graduate or have a general education development certificate equivalent. Attach **ONE** of the following (A, B, C, D, or E):

   A. U.S. High School Graduate: Attach an official, embossed transcript (academic record) or notarized copy of your high school transcript. It must have the graduation date on it. To get a copy of your high school transcript, contact your high school or its school district office.

   B. Foreign High School Graduate: Attach a notarized copy of your foreign secondary school diploma or certificate **OR** a notarized copy of your foreign secondary school transcripts. If not in English, then

include a certified translation in English. The translation may be from an evaluation service that states your education is equal to graduating high school in the U.S.

C. High School Equivalency: Attach 1, 2, or 3 to show documentation of completing one of the three High School Equivalency Tests.
   1. General Educational Development (GED): Attach an official transcript of your test results or equivalent. GED test results are official only if they are earned through an authorized GED Testing Center. To get your GED transcripts, go to http://www.gedtestingservice.com/testers/gedrequest-a-transcript. If your GED is from another state, you may need to request an official transcript of your GED test results from the agency in that state.
   2. HiSET: Attach an official transcript of your test results or equivalent. HiSET test results are official if they are earned through an authorized HiSET Testing Center. To request your HiSET transcripts, go to www.diplomasender.com.
   3. TASC: Attach an official transcript of your test results or equivalent. TASC test results are official if they are earned through an authorized TASC Testing Center. To request your TASC transcripts, go to http://www.tasctest.com/.

D. Certificate Equivalent – Attach an official "Certificate of Proficiency" showing you passed the California High School Proficiency Examination (CHSPE). To request a copy, go to https://www.chspe.net/cert-trans/ or call (866) 342-4773.

E. Out-of-State High School General Educational Development Certificate Equivalent: Attach an official transcript of your test results or equivalent.

7. REQUIRED EXPERIENCE: Submit **ONE** of the following (A, B, or C).

A. Designated Representative Experience Affidavit (form 17A-E2):
Submit this form documenting completion of a minimum of one year of paid work experience in the past three years, related to the distribution or dispensing of dangerous drugs or dangerous devices in a licensed pharmacy, drug wholesaler, drug distributor, or drug manufacturer. Do NOT include all employment dates, only paid work experience dates. An applicant may not sign as the person with direct knowledge of the applicant's experience.
   - If the one year of paid work experience was gained at multiple facilities, submit an experience affidavit form (form 17A-E2) for each facility where paid work experience was gained.
   - If your paid work experience was obtained in a facility not licensed by the California State Board of Pharmacy, you must request a License Verification to be completed by the appropriate authority which licensed the facility and submit the License Verification with your application.

B. Eligible for Pharmacist Examination: Include documentation that clearly identifies that you meet the prerequisites to take the examination required for licensure as a pharmacist. This may include an official transcript documenting your graduation from a recognized school of pharmacy, or your Foreign Pharmacist Graduate Equivalency Committee (FPGEC) certificate and completed intern hours if you are a foreign educated pharmacist.

C. Out-of-State Licensed Pharmacist: Include a copy of your current pharmacist license as well as submitting a Verification of License in Another State form (17A-16) as instructed in number 9 of the application instructions.

8. **REQUIRED TRAINING:** Designated Representative Training Affidavit (form 17A-E3). Submit this form documenting that you have completed a training program pursuant to Business and Professions Code section 4053. An applicant may not sign as the person with direct knowledge of the applicant's training. An out-of-state licensed pharmacist is not required to provide the training affidavit.

9. **VERIFICATION OF LICENSE IN ANOTHER STATE:** If you currently hold or previously held a license in another state as a pharmacist, intern pharmacist, pharmacy technician, designated representative, and/or other health care professional, request each state agency to verify your license by completing the required Verification of License in Another State form (17A-16).

10. **FINGERPRINTS:**
    - 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 you are ready to send in your application.
    - You must submit a copy of your Live Scan receipt or two rolled fingerprint cards with your application
    - Each application requires you to complete a new Live Scan or submit new fingerprint cards.
    - The Live Scan site may charge a processing fee.
    - The Board will accept fingerprint responses only from the California Department of Justice (DOJ) and Federal Bureau of Investigation (FBI).

Please complete and attach **ONE** of the following (A or B):

A. **California Resident: Attach completed Live Scan receipt.** The receipt shows you completed the Live Scan.
   - California residents must use Live Scan only.
   - To find a Live Scan location, go to https://oag.ca.gov/fingerprints/locations
   - Live Scan operators can make mistakes. You should ensure the information the operator enters is correct before they transmit your prints.

   Make sure the following information is correct when you complete your Live Scan:
   - **Type of License/Certification/Permit or Working Title:** Pharmacy Wholesaler – Section 4305.5.
   - **Full Name:** Must be EXACTLY THE SAME as the name on your 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 name on your application.
   - **Date of Birth:** Must be correct.
   - **Social Security Number (SSN) or Individual Tax Identification Number (ITIN):** Must be included and be correct, unless you have an ITIN. If you have an ITIN, this field should be left blank. **Level of Service:** Must include both DOJ and FBI.

B. Non-California Resident: You may visit California and complete Live Scan. If you cannot, then you must submit two rolled fingerprint cards with your application.

- You must use fingerprint cards from the Board of Pharmacy.
- Request fingerprint cards through the Board's online services at https://www.dca.ca.gov/webapps/pharmacy/pubs_request.php or email rxforms@dca.ca.gov.
- Fee: Include fingerprint card processing fee of $49 ($32 DOJ and $17 FBI), made payable to the Board of Pharmacy.
- You can send one check or money order for both the application processing fee and fingerprint card processing fee.
- Print legibly or type your personal information on the fingerprint cards. If your personal information is not legible and DOJ enters your information incorrectly, you will be responsible to submit new fingerprint cards and pay the $49 fingerprint card processing fee again.
- 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 about six weeks longer than Live Scan.
- Poor quality prints will be rejected and will cause delay because new fingerprint cards will be required.

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DESIGNATED REPRESENTATIVE LICENSE APPLICATION

Please read the application instructions before you complete the application. Failure to provide the required information may result in the application being considered incomplete. Attach additional sheets of paper, if necessary. The information will be used to determine if you qualify for licensure pursuant to California Business and Professions Code sections 4053.

An applicant who fails to complete all the application requirements within 60 days after being notified by the board of deficiencies, may be deemed to have abandoned the application and may be required to file a new application, fee, and meet all the requirements which are in effect at the time of reapplication.

TAPE A COLOR PASSPORT STYLE 2"X2" PHOTO TAKEN WITHIN 60 DAYS OF THE FILING OF THIS APPLICATION

NO POLAROID

OR

SCANNED IMAGES

Military Expedite (Please check one of the following, if applicable)

_____ **MILITARY** (Are you serving in the United States military?)

_____ **VETERAN** (Have you ever served in the United States military?)

_____ **ACTIVE DUTY MILITARY** (Do you have a spouse or partner serving active duty in the military?)

Applicant Information - Please Type or Print

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

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

*Official Mailing/Public Address of Record – Street/PO BOX _____ City _____ State _____ Zip Code _____

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

Telephone Numbers - Home _____ Cell _____ Work _____

Driver's License Number _____ State _____ Email Address _____

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

THIS SECTION IS FOR BOARD USE ONLY

App Fee: ___ Enf. Check: ___ Photo: ___ Experience: ____ Training: _____	HS: _____ FP Card/Fee: ___ LS: ___ DOJ Date_____ FBI Date _____	**Issuance**	**CASHIERING ONLY**	
		License #	*APPLICATION FEE*	
		Date Issued	Receipt #:	
		Date Expires	Date Cashiered:	
			Amount:	

Mandatory Education
Please indicate how you satisfy the education requirement in Business and Professions Code section 4053(b)(1).

_____ High school graduate or foreign equivalent.
Attach an official embossed transcript or notarized copy of your high school transcript, or certificate of proficiency, or foreign secondary school diploma along with a certified translation of the diploma.

_____ Completed a general education development certificate equivalent.
Attach an official transcript of your test results.

Designated Representative Qualifying Method
Please check the boxes below indicating how you qualify for a designated representative license pursuant to Business and Professions Code section 4053.

Experience
_____ I have a minimum of one year of paid work experience, in the past three years. Attached is form 17A-E2.

OR

_____ I meet the prerequisites to take the examination required for licensure as a pharmacist.

AND

Training
_____ I have completed the required training program. Attached is form 17A-E3.

License Information List all state(s) where you hold or held a license as a pharmacist, intern pharmacist, pharmacy technician, any type of designated representative, and/or other health care professional, including California.

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

APPLICANTS MUST ANSWER THE FOLLOWING QUESTIONS (Attach additional sheets of paper if necessary)

1. **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.

2. 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____

3. 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 3 (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 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.

Collection and Use of Personal Information. The California State Board of Pharmacy of the Department of Consumer Affairs collects the personal information requested on this form pursuant to Business and Professions Code sections 30 and 4000 and following and California Code of Regulations title 16, division 17. The California State Board of Pharmacy uses this information principally to identify and evaluate applicants for licensure, issue, and renew licenses, and enforce licensing standards set by law and regulation.

Access to Personal Information. You may review the records maintained by the California State Board of Pharmacy that contain your personal information, as permitted by the Information Practices Act. The official responsible for maintaining records is the Executive Officer at the board's address listed on the application. Each individual has the right to review the files or records maintained by the board, unless confidential and exempt by law.

Possible Disclosure of Personal Information. We make every effort to protect the personal information you provide us. The information you provide, however, may be disclosed under the following circumstances:

- In response to a Public Records Act request (Government Code section 6250 and following), as allowed by the Information Practices Act (Civil Code section 1798 and following);
- To another government agency as required or permitted by state or federal law; or
- In response to a court or administrative order, a subpoena, or a search warrant.

***Address of Record:** Once you are licensed with the board, the address of record you enter on this application is considered public information pursuant to the Information Practices Act (Civil Code section 1798 and following) and the Public Records Act (Government Code section 6250 and following) and will be available on the Internet. This is where the board will mail all official correspondence. If you do not wish your residence address to be available to the public, you may provide a post office box number or a personal mail box (PMB). However, if your address of record is not your residence address, you must also provide your residence address to the board, in which case your residence will not be available to the public.

****Disclosure of your U.S. social security number or Individual Taxpayer Identification Number (ITIN) is mandatory.** Section 30 of the Business and Professions Code, section 17520 of the Family Code, 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.

MANDATORY REPORTER

Under California law, each person licensed by the California State Board of Pharmacy is a "mandated reporter" for both child and elder abuse or neglect laws. California Penal Code section 11166 and Welfare and Institutions Code section 15630 require that all mandated reporters make a report to an agency specified in Penal Code section 11165.9 and Welfare and Institutions Code section 15630(b)(1) [generally law enforcement, state, and/or county adult protective services agencies, etc.] whenever the mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child, elder, and/or dependent adult whom the mandated reporter knows or reasonably suspects has been the victim of child abuse or elder abuse or neglect. The mandated reporter must contact by telephone immediately or as soon as possible to make a report to the appropriate agency(ies) or as soon as is practicably possible. The mandated reporter must prepare and send a written report thereof within two working days or 36 hours of receiving the information concerning the incident.

Failure to comply with the requirements of the laws above is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars ($1,000), or by both that imprisonment and fine. For further details about these requirements, refer to Penal Code section 11164 and Welfare and Institutions Code section 15630 and following sections.

APPLICANT AFFIDAVIT
(must be signed and dated by the applicant)

I, _____, hereby attest to the fact that I am the
Print Full Legal Name

applicant whose signature appears below. 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 this application, including all supplementary statements. I understand that my application may be denied, or any license disciplined, for fraud or misrepresentation.

_____ _____
Original Signature of Applicant Date
(please sign and date within 60 days of board receipt of the application)

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AUTHORIZATION TO RELEASE APPLICANT INFORMATION

(Optional)

The board will only disclose information pertaining to an application directly to the applicant. In order for the board to discuss the status of this application with another individual, the applicant must authorize the board in writing to discuss the application status with his or her authorized representative.

Giving consent for the board to disclose application information will authorize the board to disclose all personal 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 denied 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 the applicant, I hereby give the board consent to communicate to the individual listed below.

I, _____, hereby give consent to
Print Name of Applicant

the California State Board of Pharmacy to disclose information about my individual license 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 Applicant Date

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DESIGNATED REPRESENTATIVE EXPERIENCE AFFIDAVIT

TO BE COMPLETED BY THE PERSON HAVING DIRECT KNOWLEDGE OF APPLICANT'S PAID WORK EXPERIENCE.

The individual applying for licensure as a designated representative in California must have a minimum of one year of paid work experience in a licensed pharmacy, drug wholesaler, drug distributor, or drug manufacturer, in the past three years, related to the distribution or dispensing of dangerous drugs or dangerous devices pursuant to California Business and Professions Code section 4053. Dangerous drugs and devices are defined in Business and Professions Code section 4022.

Work Experience: To be completed by the person having direct knowledge of the applicant's PAID work experience. The applicant may not verify his/her own experience. Please provide the exact dates of training by month, day, year.

_____
Applicant's Full Name

_____ _____ _____
Date Work Experience Started | Date Work Experience Ended | Number of Months/Years of Work Experience

Work Experience Location

_____ _____
Name of Company/Employer | Pharmacy, Wholesaler, Drug Distributor, or Manufacturer License Number

_____
Address - Street | City | State | Zip Code

I certify under penalty of perjury under the laws of the State of California that all statements given on this form herein are true, and that to the best of my knowledge the experience gained by this applicant meets the requirements as required by law. I further certify that the license listed above under the work experience location of this form was not revoked, suspended, or on probation in the state during the time the work experience was gained. I understand that an application may be denied, or any license disciplined, for fraud or misrepresentation.

_____ _____
Printed Name of Person having Direct Knowledge of Applicant's Paid Work Experience | Date

_____ _____
Original Signature of Person having Direct Knowledge of Applicant's Paid Work Experience | Date

_____ _____
Telephone Number | Email Address

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DESIGNATED REPRESENTATIVE TRAINING AFFIDAVIT

TO BE COMPLETED BY THE PERSON HAVING DIRECT KNOWLEDGE OF APPLICANT'S TRAINING

The individual applying for a designated representative license in California has completed a training program required by Section 4053(b)(3) of the California Business and Professions Code that addressed, at a minimum:

A. Knowledge and understanding of California and federal laws regarding the distribution of dangerous drugs and dangerous devices;
B. Knowledge and understanding of California and federal laws regarding the distribution of controlled substances;
C. Knowledge and understanding of quality control systems;
D. Knowledge and understanding of United States Pharmacopoeia standards for the safe storage and handling of drugs; and
E. Knowledge and understanding of prescription terminology, abbreviations, dosages and format.

Training: To be completed by the person having direct knowledge of the applicant's training. The applicant may not verify his/her own training. Please provide the exact dates of training by month, day, year.

_____
Applicant's Full Name

_____ _____ _____
Date Training Started Date Training Ended Number of Training Hours/Years

Training Program: The name and location of where the training program was completed.

_____
Name of Training Program

_____
Address - Street City State Zip Code

I certify under penalty of perjury under the laws of the State of California that all statements given on this form herein are true, and that to the best of my knowledge the training gained by this applicant meets the requirements as required by law. I understand that an application may be denied, or any license disciplined, for fraud or misrepresentation.

_____ _____
Printed Name of Person having Direct Knowledge of Applicant's Training Date

_____ _____
Original Signature of Person having Direct Knowledge of Applicant's Training Date

_____ _____
Telephone Number Email Address

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VERIFICATION OF LICENSE IN ANOTHER STATE

This form must be completed by the licensing agency in each state you hold or held an individual license (e.g. pharmacist, intern pharmacist, pharmacy technician, designated representative, and/or another healthcare professional license) even if the license is no longer current or active. Please return the original state-verified form with your application for each license type. Photocopies or faxes will not be accepted.

Intern hours and licensure earned in another state may be certified by the licensing agency in each state you earned your intern hours or license on this form.

The licensee listed on this form has applied for a license in California. Before further consideration is given to this application, the California State Board of Pharmacy would appreciate your assistance in completing the information requested below. Upon completion of this form, please return it to the applicant for submission with the application.

Completed by Licensee _____ _____
Licensee's Full Name License Number

Completed by the State Licensing Board or Agency Verifying Licensure

_____	_____	_____	_____	_____
Licensure Verification Provided by the State of	License Type and License Number	Issued Date	Expiration Date	Intern Hours Earned in this State under this Intern License

License Status (Please check one) – Active _____ Inactive _____ Other _____ If other, please explain
_____

Has this agency taken any disciplinary action against this license? Yes _____ No _____

If disciplinary action has been taken against this licensee, please directly provide this office with the accusation/proposed charges and decision/final order regarding the action.

I hereby certify the information listed above is true and correct.

_____
Printed Name

Board Seal

_____
Signature

_____
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

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

Contributing Agency Information:

Board of Pharmacy
Agency Authorized to Receive Criminal Record Information

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

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

Licensing
Contact Name (mandatory for all school submissions)

Sacramento — City
CA — State
95833 — ZIP Code

9165183100
Contact Telephone Number

Applicant Information: **Live Scan Operator – The Board of Pharmacy requires you to enter the applicant's SSN.**

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 - **MANDATORY**

Misc. Number
(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