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

HOSPITAL PHARMACY LICENSE APPLICATION INSTRUCTIONS

Inpatient, Outpatient, Exempt (100 beds or fewer)

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 **Hospital Pharmacy Application and Processing Fee (All Applicants)**

Section B **Change of Ownership / Location**

Section C **Hospital Pharmacy Ownership Documents (All Applicants)** Please refer to the respective ownership sections (C1-C6) in the checklist to assist with identifying the appropriate forms and supporting documents to provide when submitting the application.

C1 Partnership

C2 Corporation (Not Publicly Traded)

C3 Publicly Traded Corporation

C4 Limited Liability Company

C5 Trust

C6 Government Owned (state, city or county)

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

CHECKLIST FOR FILING A HOSPITAL PHARMACY APPLICATION

Section A Hospital Pharmacy Application and Processing Fee (All Applicants)

1. **Hospital Pharmacy Application** (17A-19): Complete the entire application and submit with original signatures. 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. **Effective April 1, 2020, the application processing fee is $570.00.**
   Include a check or money order made payable to the California State Board of Pharmacy. This fee is nonrefundable. (NOTE: A government owned pharmacy is fee exempt.)
    - To apply for a temporary license, an additional fee of $325 must be submitted in addition to the application processing fee and the temporary hospital pharmacy license application (17A-115). If other than a change of ownership and/or location, include a written letter signed by the owner, partner, officer, member that clearly explains why it is in the best interest of the public for the Board to issue a temporary license. This fee is nonrefundable.

3. **Organizational Chart:** Include a business ownership organizational chart that clearly documents the applicant's business ownership structure. Include each level of ownership with corresponding percentage of ownership to the top tier, 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.

4. **Financial Affidavit in Support of Application** (17A-2): Complete and submit with original signatures. (*Note: Not needed for a change of location, a nonprofit organization, government, or tribal owned.)*

5. **Approved Wholesale Credit Application or Wholesale Agreement**): Submit a completed approved wholesale credit application/agreement. (Note: *Not needed for nonprofit organization or government)*

6. **Lease Agreement/Grant Deed:** Submit a copy of the signed lease agreement, including any amendments and/or extensions, or a copy of the grant deed.
    - A lease agreement should include language stating the landlord is complying with California Business and Professions Code section 4116 and Title 16, California Code of Regulations section 1714(d). If the lease does not include specific language regarding compliance with Pharmacy Law, please provide a written statement signed by both the landlord and tenant, that includes the following to demonstrate the landlord acknowledges California Pharmacy Law pertaining to is authorized to access the pharmacy. (Government owned facilities, please submit a signed statement as described.)
        1. No person shall be permitted entry into a premises licensed by the Board of Pharmacy unless a registered pharmacist is present at all times pursuant to Business and Professions Code section 4116;
        2. Title 16, California Code of Regulations section 1714(d) provides that only a licensed pharmacist may have a key to an area where dangerous drugs and controlled substances are stored;
        3. No lease for a licensed premises may contain a provision inconsistent with Business and Professions Code section 4116 or Title 16, California Code of Regulations section 1714(d); and
        4. The landlord and tenant desire to clarify the lease with respect to Landlord's ability to access the premises.

7. **General Acute Care Hospital License:** Submit a copy of the general acute care hospital license issued by the California Department of Public Health.

8. If you are a Knox Keene provider, please provide a copy of your current California Department of Corporations license.

9. If the pharmacy is not operated by the hospital, provide a signed copy of the management agreement.

10. **Exempt Hospital** (100 beds or fewer): In addition to Section C and D, submit the following:
    - A Certification of Personnel (17A-11) form for each individual listed below.
        - Administrator
        - Medical Director

Section B Change of Ownership / Location

A hospital pharmacy 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 items listed in Section A, C, and D, include the following item when submitting 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 pharmacy license prior to the issuance of the license.
    - Organizational Chart: Submit a business ownership organizational chart that clearly documents the applicant's business ownership structure with the application. Include both the pre- and post-business ownership structure that includes each level of ownership with corresponding percentage of ownership to the top tier, percentages owned by all parties, and list the top five executive officers under the appropriate entity.

2. **Change of Location as a result of a Natural Disaster or Declared Federal, State, or Local Emergency**
    A pharmacy that is destroyed or severely damaged as a result of a natural disaster or due to events that led to a declared federal, state, or local emergency, may be relocated. The relocation shall not be considered a transfer of ownership or location under Section 4029, if there are no changes made to beneficial interest and the management and control of the pharmacy. Severely damaged means damage that renders the premises unsafe or unfit for entry or occupation. [BPC 4062]

    Submit the following items listed above in Section A for notification of relocation under this circumstance.
    - Complete the Hospital Pharmacy Application (17A-19) and submit with original signatures. The application fee is waived.
    - Submit a copy of the general acute care hospital license issued by the California Department of Public Health.

Section C Hospital Pharmacy Ownership Documents (All Applicants)

California Business and Professions Code section 4035 specifies "person" includes, but is not limited to, 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. This may include multiple levels of ownership. The Board may require additional documentation to confirm or substantiate the reported ownership structure.

Provide ownership documents listed under the appropriate ownership type in Section C for the applicant business and each level of ownership.

C1 Partnership In addition to items listed in Section A and D, submit the following:

1. Ownership Information (17A-33): Complete the entire form and submit with original signatures. Complete the entire form for each parent entity holding beneficial interest and/or management and control (one for each level of ownership up to the top tier), if applicable.

2. Each partner and executive officer submit:
    - Individual Personal Affidavit (17A-27) *Not required for nonprofit*
    - Certification of Personnel (17A-11)
    - Individual Financial Affidavit (17A-26) *Not required for nonprofit or change of location.*

3. Partnership Agreement: Current executed partnership agreement for the applicant business.

   If a partner is an entity, complete and provide the appropriate ownership documents listed under Section C for each partner.

C2 Corporation (Not Publicly Traded) In addition to items listed in Section A and D, submit the following:

1. Ownership Information (17A-33): Complete the entire form and submit with original signatures.
    - Complete the entire form for each parent entity holding beneficial interest and/or management and control (one for each level of ownership up to the top tier), if applicable.

2. Each corporate officer, major shareholder, and director submit:
    - Individual Personal Affidavit (17A-27) Not required for nonprofit
    - Certification of Personnel (17A-11)
    - Individual Financial Affidavit (17A-26) Not required for nonprofit or change of location.

3. Articles of Incorporation: A copy 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) Submit 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 (If required by the California Secretary of State).*
5. Stock Certificates and Stock Ledger: Provide a copy of stock certificate(s) front and back (this includes cancelled stock certificates) along with a copy of the stock ledger. If stocks are not issued, please provide a statement that states as such.

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

C3 Publicly Traded Corporation In addition to items listed in Section A and D, submit the following:

1. Ownership Information (17A-33): Complete the entire form and submit with original signatures.
    - Complete the entire form for each parent entity holding beneficial interest and/or management and control (one for each level of ownership up to the top tier), if applicable.

2. Each corporate officer, major shareholder, and director for the applicant business must submit:
    - Individual Personal Affidavit (17A-27) Not required for nonprofit
    - Certification of Personnel (17A-11)
    - Individual Financial Affidavit (17A-26) Not required for nonprofit or change of location.

3. 10K Filing: Include a copy of the document filed with the Securities Exchange Commission.

4. A list of the five largest shareholders who own ten (10) percent or more of stock which requires a filing with the Securities Exchange Commission. If no shareholder holds more than ten (10) percent of stock, please provide a statement signed by a binding officer stating as such.

C4 Limited Liability Company In addition to items listed in Section A and D, submit the following:

1. Ownership Information (17A-33): Complete the entire form and submit with original signatures.
    - Complete the entire form for each parent entity holding beneficial interest and/or management and control (one for each level of ownership up to the top tier), if applicable.

2. Each member/manager/executive officer submit:
    - Individual Personal Affidavit (17A-27) Not required for nonprofit
    - Certification of Personnel (17A-11)
    - Individual Financial Affidavit (17A-26) Not required for nonprofit or change of location.

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

4. Statement of Information (a or b):
    a) Submit 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 Entity **endorsed** by the California Secretary of State. *This is only required if the named entity on the application is organized outside of California (If required by the California Secretary of State).*

5. Operating Agreement: Current business operating agreement for the applicant business, including all exhibits and/or schedules. (Redacted copies will not be accepted.)

C5 **Trust** In addition to items listed in Section A and D, submit the following:

1. Ownership Information (17A-33): Complete the entire form and submit with original signatures.
    - Complete the entire form for each parent entity holding beneficial interest and/or management and control (one for each level of ownership up to the top tier), if applicable.

2. Each trustee, of the first level of ownership, submit:
    - Individual Personal Affidavit (17A-27) Not required for nonprofit
    - Certification of Personnel (17A-11)
    - Individual Financial Affidavit (17A-26) Not required for nonprofit or change of location.

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. The documentation shall include a statement that the trustee(s) and/or beneficiaries are in compliance with California Business and Professions Code section 4111.

C6 **Government Owned (city, state, and county)** In addition to items listed in Section A, submit the following:

1. Ownership Information (17A-33): Complete the entire form and submit with original signatures.

2. The Administrator must submit a Certification of Personnel (17A-11)

3. Letter of Verification: Submit a letter of verification on letterhead from the county public health department, health district, or the board of supervisors indicating that the facility is government owned.

4. Professional Director: Submit a statement on letterhead signed by the appropriate governing authority indicating the name of the professional director or responsible party for the pharmacy operation.

5. Organizational Structure: Provide an organizational chart that clearly identifies the administrator or the person responsible for the operations of the pharmacy within the government agency.

Section D Fingerprint Requirements (All Applicants)

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

ALL ownership types must complete the fingerprint requirement (Government owned facilities are exempt from this requirement.). Business and Professions Code section 4201(a) requires "the application shall state the information as to each person beneficially interested or any person with management or control over the license." With the addition of management or control over the license, officers/owners of nonprofit corporations will be required to have their fingerprints completed through the Department of Justice and Federal Bureau of Investigation.

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 separate from that payable to the Board.
- 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 – 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, 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 fingerprinted individual is not legible and DOJ enters the information incorrectly, he/she will have to submit new fingerprint cards and pay the $49 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.
- The fingerprint card must be completed in black ink.

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HOSPITAL PHARMACY LICENSE APPLICATION

Inpatient, Outpatient, Exempt Hospital (100 beds or less)

1. Applicant Information (Name of Hospital Pharmacy cannot exceed 65 characters including spaces)

_____
Name of Hospital Pharmacy as it will appear on the License – may include DBA

_____
If different from above, list Legal Name of Hospital Pharmacy

_____
Location of Hospital Pharmacy Number and Street City State Zip Code

_____ _____
Email Address of Hospital Pharmacy Telephone Number

2. Type of Pharmacy

____ Inpatient

____ Outpatient (Check all that apply)
- ___ Retail
- ___ Home Health Care
- ___ Skilled Nursing Facility

____ Exempt Hospital 100 beds or less (Drug Room)

3. Type of Application ___ Temporary License Request – Submit Temporary Application 17A-101 and Fee

___ New Hospital Pharmacy _____ Anticipated Opening Date
___ Change of Ownership _____ Anticipated Change of Ownership Date
___ Change of Location: _____ Anticipated Move Date
Is this change of location a result of a declared federal, state, or local emergency? ___ Yes ___ No

4. Type of Ownership

___ Individual
___ Partnership
___ Limited Liability Company
___ Trust
___ Corporation
___ Nonprofit Corporation
___ Publicly Traded Corporation
___ Not Publicly Traded Government
___ Native American Tribe
___ Non-Native American Operating on Tribal Lands

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

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

5. **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 may communicate deficiencies and status of application to the contact person via email.

_____ _____ _____
Name of Contact Person Telephone Number Email Address

_____
Address: Street City State Zip Code

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

_____ _____
Name listed on the Current Hospital Pharmacy License License Number

_____
Address: Street City State Zip Code

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

7. **Pharmacist-in-Charge (PIC)** List the proposed Pharmacist-In-Charge (PIC) to serve as the supervisor or manager responsible for ensuring the pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy as well as the pharmacy's policy and practices. The PIC must be approved by the board.

_____ _____
Name of PIC Pharmacist License Number

_____ _____
Telephone Number of PIC Email Address

_____ _____
Original Signature of PIC Date

8. **Hospital Pharmacy Premises** (Check one) Submit a copy of the Lease Agreement or Grant Deed with the application.

___ **Premises are leased/rented:** Submit a copy of the lease/rental agreement

If the premises are leased/rented, are they leased/rented from a person who is licensed in California to prescribe?

___ Yes ___ No If yes, provide confirmation of compliance with California Business and Professions Code section 650.1.

___ **Premises are owned:** Submit a copy of the grant deed

9. Hospital Pharmacy Business Operation

A. Provide the Hospital's California Department to Health License Number _____

B. Is the pharmacy located at the primary hospital address?

____ Yes ____ No If No, entered address below.

_____

Address of Pharmacy: Number and Street City State Zip Code

C. Is the pharmacy operated by the hospital?

____ Yes ____ No If No, provide management company information below and submit a copy of the management agreement.

_____ _____

Name of Management Company Telephone Number

_____

Address: Number and Street City State Zip Code

_____ _____

Contact Person at Management Company Email Address

D. Were you qualified as a Knox-Keene provider before August 1, 1981?

____ Yes ____ No If yes, provide a copy of the current license from the California Department of Managed Health Care (DMHC)

10. Drugs Stored (Check all that apply in the hospital where drugs are stored)

____ Nursing Station ____ Satellite Pharmacy ____ Drug/Night Locker ____ Emergency Locker

____ Other: Specify: _____

EXEMPT HOSPITAL ONLY

A. Number of Beds_____

B. Does the hospital employ a full-time pharmacist? ____ Yes ____ No

If yes, you must apply as an inpatient hospital pharmacy.

If yes, name of full-time pharmacist_____ License Number_____

If no, name of consulting pharmacist_____ License Number _____

Name of Medical Director_____ License Number _____

Name of Administrator _____ License Number_____

APPLICANT AFFIDAVIT - Read carefully and sign below.

This application must be approved by the California State Board of Pharmacy before a hospital pharmacy license will be issued. The applicant hospital pharmacy 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 will 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 instant 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 withdrawal of an application for a license after it has been filed with a board in the department shall not, unless the board has consented in writing to such withdrawal, deprive the board of its authority to institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground." (Bus. & Prof. Code § 118, subd. (a).)

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, (916) 518-3100, 2720 Gateway Oaks Blvd., Suite 100, Sacramento, CA 95833. 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 Board of Pharmacy, unless the records are identified as confidential and exempted by Civil Code section 1798.38.

*Disclosure of your social security number if you are a sole proprietor or federal employer identification number ("FEIN") if you are a partnership is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes or compliance with any judgment or order for family support in accordance with section 17520 of the Family Code. If you fail to disclose your social security number or your FEIN, your application for initial or renewal license will not be processed AND you may be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

**Residence address will not be made available to the public.

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.

REQUIRED SIGNATURES: All natural persons authorized to bind the applicant business are required to sign the application.

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

1. The **owner, partner, member, officer, director, manager, trustee, or the administrator (government owned)** of the applicant pharmacy named in the foregoing application, is 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 that each and all statements therein made are true.
3. No person other than the applicant or applicants has any direct or indirect interest or management and control in the applicant hospital pharmacy business to be conducted under the license for which this application is made.
4. Understands that falsification of any information in this application may constitute grounds for denial or subsequent revocation of the license.
5. All supplemental statements are true and accurate.
6. 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

_____ _____

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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OWNERSHIP INFORMATION

(Individual, Partnership, Corporation, Limited Liability Company, Trust, Government)

This form is completed by each "person" (parent, grandparent, etc.) in the ownership structure for the applicant business that is an Individual, Partner, Corporation, Limited Liability Company, Trust, Government, and Indian Tribe owned. 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.

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

Submit a business ownership organizational chart that clearly documents the applicant's business ownership with the application. Include each level of ownership with corresponding percentage of ownership to the top tier.

Please identify the business this form is being completed for:

A. Applicant Business _____
B. Owner/Parent _____

A. Applicant Information

_____
Name of Applicant Business

_____
Address of Applicant Business Street City State Zip Code

B. Name of Owner

_____
Name of Parent Entity

_____
Address Street City State Zip Code

_____ _____
Email Address Telephone Number

C. Officer/Director/Trustee/Manager/Administrator

Provide the name(s) of the top five officer(s), director(s), trustee(s), managers, and the Administrator (government owned). Under the heading "License" list any state professional or vocational license(s) (current or expired) - e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc. Nonprofit organizations must list the names and titles of persons holding corporate positions. If licensed, include the license type, license number, and the state(s) licensed in below. **LIST ALL TITLES, IF SERVING IN MORE THAN ONE CAPACITY.**

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

D. Owners/Shareholders of Corporation or Limited Liability Company

List all "persons" who own an interest in this corporation or limited liability company. If more than five shareholders, please list the top five largest (Additional information may be required.) List certificates chronologically, including active, cancelled, and pending issuance. If stock is pledged, include date, number of shares, and from whom to whom. Attach a copy of all stock certificates, transfer ledgers, and proof of purchase issued to date. Under the heading "License" list any state professional or vocational license(s) (current or expired) - e.g., pharmacist, physician, podiatrist, dentist or veterinarian, etc. Nonprofit organizations must list the names and titles of persons holding corporate positions. If licensed, include the license type, license number, and the state(s) licensed in below.

Name of Person Stocks are Issued	Cert # or NA	% of Shares	Date Issued	Date Cancelled	License

E. Ownership

If no stockholders exist, list all "persons" with a beneficial interest or management or control of the license below. Under the heading "License Type" list any state professional or vocational licenses held - e.g., pharmacist, physician, podiatrist, dentist, veterinarian, etc. - and the license number if a natural person.

_____ _____

Name of "Person" % Owned

_____

Address Street City State Zip Code

_____ _____ _____ _____ _____

*US Social Security Number/FEIN License Type License Number Expiration Date State Licensed in

_____ _____

Name of "Person" % Owned

_____

Address Street City State Zip Code

_____ _____ _____ _____ _____

*US Social Security Number/FEIN License Type License Number Expiration Date State Licensed in

_____ _____

Name of "Person" % Owned

_____

Address Street City State Zip Code

_____ _____ _____ _____ _____

*US Social Security Number/FEIN License Type License Number Expiration Date State Licensed in

PLEASE READ CAREFULLY – NATURAL PERSONS LISTED ON THIS FORM SIGN BELOW.

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

This application must be approved by the California State Board of Pharmacy before a license will be issued. If changes are made during the application process, you may need to submit a new application with the 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 which are in effect at the time of application. Fees applied to this application are not transferable and are not 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 may constitute grounds for denial or subsequent revocation of license and a violation of the California Penal Code.

The information provided will be used to determine if qualifications for licensure under the California Pharmacy Law has been met. The official responsible for maintaining records is the Executive Officer at the

board's address listed on the application. 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 by the board, unless confidential and exempt by law.

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.

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

1) Is the owner, officer, director, manager, partner, member, trustee, or the Administrator (government owned) 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.
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) No person other than the applicant or applicants has any direct or indirect interest or management and control in the applicant business to be conducted under the license for which this application is made.
4) Understands that falsification of any information in this application may constitute grounds for denial or subsequent revocation of the license.
5) 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.

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

FINANCIAL AFFIDAVIT IN SUPPORT OF APPLICATION

All items of information in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information will be used to determine qualifications for registration under the California Pharmacy Law. The official responsible for information maintenance is the executive officer, at the address listed above. The information may be transferred to another governmental agency such as a law enforcement agency if necessary, for it to perform its duties. Each individual has the right to review the files or records maintained on them by our agency, unless the records are identified as confidential information and exempted by section 1798.3 of the Civil Code.

Please print or type. All blanks must be completed; if not applicable, enter N/A.

1. Applicant Information

_____
Name of Applicant Business

_____
Address of Applicant Business Street City State Zip Code

2. Indicate what part of the total investment will be in cash, and from what source(s) it will be or has been derived. **Please attach documentation**.

Amount $_____

Source _____

_____

_____

3. List all other sources of funding for the pharmacy and how it will be paid. Provide the name, address, telephone number and amount. Use additional sheets if necessary.

Amount $_____

_____ _____
Name of source Telephone Number

_____
Address Street City State Zip Code

Source _____

_____

4. If the pharmacy is franchised, list the name of franchisor. Please include the franchise agreement.

_____

5. Who will be the **primary** wholesaler for dangerous drugs and/or dangerous devices? Please attach an **approved** wholesale credit application or wholesale agreement.

_____ _____

Name of Primary Wholesaler Telephone Number

_____

Address Street City State Zip Code

6. Who will be the **secondary** wholesaler for dangerous drugs and/or dangerous devices? Please attach an **approved** wholesale credit or wholesale credit application or wholesale agreement.

_____ _____

Name of Secondary Wholesaler Telephone Number

_____

Address Street City State Zip Code

7. Business Bank Information – Please submit a copy of most recent bank statement for each account listed.

_____ _____ _____ _____

Bank Name Telephone Number Account Number Balance of Account

_____

Address Street City State Zip Code

_____ _____ _____ _____

Bank Name Telephone Number Account Number Balance of Account

_____

Address Street City State Zip Code

List all individuals authorized to sign on business bank account.

_____ _____ _____

Signature Name (please print) Title

_____ _____ _____

Signature Name (please print) Title

_____ _____ _____

Signature Name (please print) Title

_____ _____ _____

Signature Name (please print) Title

8. Bookkeeper/Accountant Information

_____ _____

Name of Bookkeeper/Accountant for Applicant Premises Telephone Number

_____

Address Street City State Zip Code

Estimated Annual Gross Sales $_____ Estimated Annual Purchases $_____

APPLICANT(S) AUTHORIZATION FOR DISCLOSURE OF FINANCIAL RECORDS

From this date until the issuance of this license, for the purpose of authorizing the Board of Pharmacy to conduct an investigation on my/our qualifications pursuant to section 4207 of the Business and Professions Code, I hereby authorize the California State Board of Pharmacy, or any of its authorized personnel to examine and secure copies of financial records consisting of signature cards, checking and savings accounts, notes and loan documents, deposit and withdrawal records, and escrow documents of my/our financial institution(s) or any financial records established in connection with this business.

I also authorize the California State Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of any business records or documents established in connection with this business, including, but not limited to, those on file with my/our bookkeeper/accountant or with the escrow holder. I agree to furnish current financial information on the annual renewal if requested by the California State Board of Pharmacy.

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 application, including all supplementary statements.

1. Is the owner, a partner, a member/manager, an officer, a director, a trustee, or a tribal council member (Native American owned) of the applicant pharmacy named in the foregoing application, is 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 that each and all statements therein made are true.
3. Understands that falsification of any information in this application may constitute grounds for denial or subsequent revocation of the license.
4. All supplemental statements are true and accurate.

_____ _____ _____

Signature Name (please print) Title Date

Notary Public

_____ _____ _____

Attest Notary Public Place Date

California State Board of Pharmacy
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Sacramento, CA 95833
Phone: (916) 518-3100 Fax: (916) 574-8618
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Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

INDIVIDUAL PERSONAL AFFIDAVIT

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

NO POLAROID OR SCANNED IMAGES

1. Applicant Information - Please Type or Print

_____
Name of Applicant Business

_____
Address of Applicant Business Street

_____
City State Zip Code

2. Individual Information

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

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

_____
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

3. My position with the applicant business is (check all that apply):
____ Sole Owner ____ Director ____ Stockholder _____% owned ____ Partner ____ Officer
____ Member and/or Manager (LLC only) ____ Other, please specify_____

4. Spouse Information

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

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

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

Will your spouse work in any capacity under the license? ____ Yes ____ No
If yes, what capacity? _____ If Licensed, list license number _____

5. Do you have, or have you had, any direct or indirect beneficial interest in any other premises license by any board of pharmacy? Include sites licensed in states other than California.
____ Yes ____ No
If yes, list all current and past direct or indirect beneficial interests below. Attach additional sheets if necessary.

Name of Premises	License Number	State Issued

Address: Street	City	State	Zip Code

Name of Premises	License Number	State Issued

Address: Street	City	State	Zip Code

Name of Premises	License Number	State Issued

Address: Street	City	State	Zip Code

6. 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, physician, nurse practitioner, physician assistant, podiatrist, optometrist, veterinarian, dentist, attorney, contractor, 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, physician, nurse practitioner, physician assistant, podiatrist, optometrist, veterinarian, dentist, attorney, contractor, 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____

If any of the above actions have occurred with your spouse or palimony partner, or an associate with whom you have shared any ownership interest, attach a statement of explanation that describes the event, regulatory agency involved and date for each incident.

7. Current and Past Employment for at least the last five years.

From mm/yy	To mm/yy	Type of Work	Firm Name and City
From mm/yy	To mm/yy	Type of Work	Firm Name and City
From mm/yy	To mm/yy	Type of Work	Firm Name and City

Please Read Carefully

**Disclosure of your social security number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes of compliance with any judgment or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code, or for verification of examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you."

NOTICE: Effective July 1, 2012, 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.

Certification Signature

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license. I hereby authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of financial records consisting of signature cards, checking and savings accounts, note and loan documents, deposit and withdrawal records, and escrow documents of my financial institution(s) or any financial records established in connection with this business. This authorization to examine records at any financial institution may be at any time. I also authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of any business records or documents established in connection with this business including, but not limited to those on file with my bookkeeper.

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 individual personal affidavit, including all supplementary statements and I personally completed this personal affidavit.

Applicant's Signature	Title	Date

Notary Public

Attest Notary Public	Place	Date

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Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

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

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Business, Consumer Services and Housing Agency
Department of Consumer Affairs
Gavin Newsom, Governor

INDIVIDUAL FINANCIAL AFFIDAVIT

Please print or type.

Personal Information – Do not leave blanks, if not applicable, indicate NA.

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

_____
Residence Address - Street City State Zip Code

_____ _____ _____
Telephone Numbers - Home Cell Work

Applicant Business Information

_____ _____
Name of Applicant Business Business Telephone Number

_____
Applicant Business Address - Street City State Zip Code

You must indicate one or more of the following:

____ I am making a contribution: Total amount $_____ cash amount $_____
____ I am contributing labor/expertise only valued at $_____
____ I am receiving a loan: total amount $_____(please attach copy of loan agreement)
____ I am making a loan: total amount $_____(please attach copy of the loan agreement)
____ I am not making a contribution in any form.

SOURCE OF FUNDS USED TO FINANCE BUSINESS

INSTRUCTIONS: Fully explain the source of your financial contributions (e.g. stock/bonds, real estate). If cash funds are from savings, indicate where the money was or is kept. If the source is from the sale of property, indicate what was sold, the address (if real estate), the name and address of the buyer, and the net proceeds from the sale. If a loan is involved, show the date, amount, terms, security, name and address of the lender. Describe any other sources of funds such as inheritances or gifts. Documentation may be requested.

SAVINGS (Please use additional sheets if necessary)

Financial Institution(s)	City and State	Amount	Account Number	Source of Savings

CHECKING (Please use additional sheets if necessary)

Financial Institution(s)	City and State	Amount	Account Number	Source of Checking

LOANS & CREDIT APPLICATIONS FOR THIS BUSINESS (Please use additional sheets if necessary)

Date(s)	Amount(s)	Term(s)	Item(s) Secured	Security(s)	Lender(s)

SALE OF PROPERTY TO FINANCE THIS BUSINESS (Please use additional sheets if necessary)

Type	Date Sold	Buyer	Net Proceeds	Other Source(s)

Location of Property: _____

Type	Date Sold	Buyer	Net Proceeds	Other Source(s)

Location of Property: _____

Will funding be provided in any amount from an individual, partnership or corporation whose professional or vocational license has been revoked, denied or in any other manner disciplined by a regulatory board in California or any other state?

Yes ____ No ____

If yes, please explain fully below (attach additional sheets if necessary). Attach copies of all disciplinary orders.

_____

_____

_____

_____

_____

_____

_____

Please read and sign below in the presence of a Notary Public.

For this application, from this date and pursuant to section 4207 of the Business and Professions Code, I hereby authorize the California State Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of financial records consisting of signature cards, checking and savings accounts, note and loan documents, deposit and withdrawal records, and escrow documents of my financial institution(s) or any financial records established in connection with this business. This authorization to examine records at any financial institution may occur at any time. I also authorize the Board of Pharmacy, or any of its authorized personnel, to examine and secure copies of any business records or documents established in connection with this business including, but not limited to, those on file with my bookkeeper.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license.

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 Individual Financial Affidavit, including all supplementary statements and I personally completed this financial affidavit.

_____	_____	_____
Signature	Tittle	Date

Notary Public

_____	_____	_____
Attest Notary Public	Place	Date

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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

Pharmacy - 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