State of Utah
Department of Commerce
Division of Occupational and Professional Licensing

Official Use Only
Number: _____
Date Approved/Denied: _____
Approved/Denied By: _____

Pharmacy- Class B

APPLICANT INFORMATION

Business Legal Name _____
**Note: If you are a Sole Proprietor, this is your legal name.*

DBA ***(if applicable):*** _____

Address: _____
Street Address (including Apt/Unit/Ste #)

_____
City *State* *ZIP Code*

Phone: _____ **Email:** _____

Contact for Licensing Purposes: _____

Phone: _____ **Email:** _____

AFFIDAVIT AND RELEASE

1. I certify that I am qualified in all respects for the license for which I am applying in this application.
2. I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.
3. I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.
4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.
5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.
6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Authorized Signer: _____ Date: _____

Printed Name of the Authorized Signer: _____

Position of Authorized Signer: _____

BUSINESS ORGANIZATION

Please select entity type:

- ☐ Business Trust
- ☐ Corporation
- ☐ General Partnership
- ☐ Limited Liability Company
- ☐ Limited Partnership
- ☐ Limited Liability Partnership

If registered as one of the above entities, complete only Section 1 below.

☐ Sole Proprietorship
If registered as sole proprietorship, complete only Section 2 below.

Section 1: To be completed by Corporation, LLC, LP and LLP applicants only.

UT Division of Corporation Registration Number: _____ Tax Id Number: _____

Select one: ☐ Domestic ☐ Foreign Is this company publicly traded? ☐ Yes ☐ No

DBA (if applicable) : _____ DBA Registration Number: _____

**It is required that all entities doing business in Utah register with the Division of Corporation and Commercial Code.*

I understand that in all areas of this application the words "you", "I" and "applicant" apply to the entity listed above and all subsidiaries, owners, officers, managers, qualifiers and prior entities for which these individuals have been involved.

Signature of Authorized Signer: _____ Date: _____

Printed Name of the Authorized Signer: _____

Position of Authorized Signer: _____

Section 2: To be completed by Sole Proprietorship applicants only.

Full Legal Name: _____
First *Middle* *Last*

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

Please Select ONE:

- ☐ I am a United States citizen OR a non-citizen of the United States who is lawfully present.
- ☐ I am a foreign national not physically present in the United States.
- ☐ None of the above, please explain: _____

Driver License or State ID Card _____
State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Drivers License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of authorization to work in the United States.

If applicable, please complete the following:

UT Division of Corporation Registration Number: _____ Tax Id Number: _____

DBA: _____ DBA Registration Number: _____

QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1.	☐ Yes ☐ No	Have you ever had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, or disciplined in any way?
2.	☐ Yes ☐ No	Have you ever been permitted to resign or surrender your license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending against you by any professional licensing agency or criminal or administrative jurisdiction?
3.	☐ Yes ☐ No	Are you currently under investigation or is any disciplinary action pending against you now by any *local, state or federal licensing, enforcement or regulatory agency?*
4.	☐ Yes ☐ No	Have you ever been declared by any court to be incompetent by reason of mental defect or disease and not restored?
5.	☐ Yes ☐ No	Have you ever had a documented case in which you were involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
6.	☐ Yes ☐ No	Have you been terminated, suspended, reprimanded, sanctioned, or asked to leave voluntarily from a position because of drug or alcohol use or abuse within the past five (5) years?
7.	☐ Yes ☐ No	Are you currently using or have you recently (*within 90 days*) used any drugs (*including recreational drugs*) without a valid prescription, the possession or distribution of which is unlawful under applicable state or federal laws?
8.	☐ Yes ☐ No	Have you ever unlawfully used any drugs for which you have not successfully completed, or are not now participating in a supervised drug rehabilitation program, or for which you have not otherwise been successfully rehabilitated?
9.	☐ Yes ☐ No	Do you currently have any criminal action pending?*****
10.	☐ Yes ☐ No	Have you pled guilty to, no contest to, entered into a plea in abeyance or been convicted of a misdemeanor in any jurisdiction within the past ten (10) years? *****
11.	☐ Yes ☐ No	Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?*****
12.	☐ Yes ☐ No	Have you ever been incarcerated for any reason in any correctional facility (*domestic or foreign*) in any jurisdiction or on probation/parole in any jurisdiction?*****

***NOTE:* Charges that were later dismissed and motor vehicle offenses such as driving while impaired or intoxicated must be disclosed; however, minor traffic offenses such as parking or speeding violations need not be listed.**

If you answered **"Yes"** to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

If you answered **"Yes"** to Questions **9,10,11** or **12** you must submit the following for **EACH** and **EVERY** incident:

- Personal account of the incident
- police report(s)
- court record(s)
- probation/parole officer report(s)

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

REASON FOR APPLICATION

Select all that apply

☐ New Facility

☐ Change of Name
Utah License Number: _____
Current Name: _____
Effective Date of Change _____

☐ Change of Location or Remodel
Utah License Number: _____
Current Address _____
Proposed Date of Change: _____

☐ Change of Ownership of Existing Pharmacy
Utah License Number: _____
Effective Date of Change: _____

CLASS B SUBTYPE

Please select the subtype that you are applying for:

☐ Branch Pharmacy: A "branch pharmacy" means a pharmacy or other facility in a rural or medically underserved area used for the storage and dispensing of prescription drugs, which is dependent upon, stocked by and supervised by a pharmacist in another licensed pharmacy designated and approved by the division as the parent pharmacy.

☐ Closed Door: A "closed door pharmacy" means a pharmacy that provides pharmaceutical care to a defined and exclusive group of patients who have access to the services of the pharmacy because they are treated by or have an affiliation with a specific entity, including a health maintenance organization or an infusion company, but not including a hospital pharmacy, a retailer of goods to the general public, or the office of a practitioner.

☐ Narcotic Treatment Program Pharmacy: A "Narcotic Treatment Program Pharmacy" is a clinic which has been established for the dispensing of methadone, a schedule II opioid analgesic, to those who abuse heroin and other opioids.

☐ Nuclear Pharmacy: A "nuclear pharmacy" means a pharmacy providing radio-pharmaceutical service.

☐ Pharmaceutical Administration Facility: A "pharmaceutical administration facility" means a facility, agency, or institution in which:

- (a) prescription drugs or devices are held, stored, or are otherwise under the control of the facility or agency for administration to patients of that facility or agency;
- (b) prescription drugs are dispensed to the facility or agency by a licensed pharmacist or pharmacy intern with whom the facility has established a prescription drug supervising relationship under which the pharmacist or pharmacy intern provides counseling to the facility or agency staff as required, and oversees drug control, accounting, and destruction; and
- (c) prescription drugs are professionally administered in accordance with the order of a practitioner by an employee or agent of the facility or agency.

PHARMACIST IN CHARGE / CONSULTING PHARMACIST

All Class B pharmacies require a PIC *except* for pharmaceutical administration facilities and methadone clinics. If your pharmacy is not required to have a PIC, you must provide fingerprints for the Consulting Pharmacist

NOTE: In addition to completing this section, you must submit two completed fingerprint cards for the PIC, see the checklist at the end of this application for additional information regarding fingerprints.

Full Legal Name: _____
First *Middle* *Last*

Mailing Address: _____
Street/PO Box *City* *State/Zip*

License Number _____ **State of Issue:** _____

I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

Signature of PIC/CP: _____ Date _____

PHARMACIST IN CHARGE SUPERVISOR / ON-SITE SUPERVISOR

All Class B pharmacies require a PIC *except* for pharmaceutical administration facilities and methadone clinics. If your pharmacy is not required to have a PIC, you must provide fingerprints for the on-site employee responsible to ensure the pharmacy follows all laws and rules pertaining to the practice of pharmacy.

NOTE: In addition to completing this section, you must submit two completed fingerprint cards for the PIC's immediate supervisor or the On-Site Supervisor; see the checklist at the end of this application for additional information regarding fingerprints.

Full Legal Name: _____
First *Middle* *Last*

SSN: _____ **Date of Birth:** _____ **Gender:** ☐ Male ☐ Female

I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

Signature of Supervisor: _____ Date _____

MEDICAL QUALIFYING QUESTIONNAIRE

Read thoroughly, and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:

☐ Yes ☐ No a hospital or health care facility

☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program

☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency

☐ Yes ☐ No malpractice insurance coverage

☐ Yes ☐ No other entity: _____

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:

☐ Yes ☐ No a hospital or health care facility

☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program

☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency

☐ Yes ☐ No malpractice insurance coverage

☐ Yes ☐ No other entity: _____

3. Is any action pending against you now by:

☐ Yes ☐ No a hospital or health care facility

☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program

☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency

☐ Yes ☐ No malpractice insurance coverage

☐ Yes ☐ No other entity: _____

4. ☐ Yes ☐ No Have you been named as a defendant in a malpractice suit?

5. ☐ Yes ☐ No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered **"Yes"** to question 4 you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website: http;//www/npdb.hrsa.gov.*

If you answered **"Yes"** to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

UTAH CONTROLLED SUBSTANCE AFFIDAVIT (OPTIONAL)

If you are applying for a controlled substance license, you must read and sign the affidavit below.

1. I have reviewed and understand that I must abide by the additional laws and rules that govern the practice of my profession as it pertains to controlled substances.

2. I understand that there may be additional continuing education requirements for those who hold a controlled substance license.

3. I understand it is required that I hold a valid Federal Drug Enforcement Administration (DEA) registration.

Signature of Applicant: _____ Date _____

Note: *In addition to signing this affidavit, you must complete the items listed on the OPTIONAL CONTROLLED SUBSTANCE LICENSE checklist at the end of this application.*

CLASS B CONTROLLED SUBSTANCE DATABASE QUESTIONNAIRE

To be completed by the pharmacist-in-charge or consulting pharmacist if PIC is not required by law of all facilities that dispense controlled substances to any person in Utah other than an inpatient in a licensed health care facility.

PIC/CP: _____ **Email:** _____

Pharmacy Name: _____ **Email:** _____

Pharmacy Address: _____

Street Address (including Apt/Unit/Ste #) *City* *State* *ZIP*

Pharmacy Telephone: _____ **Pharmacy Fax:** _____

Software Vender:

- ☐ Foundation Systems (FSI)
- ☐ PDX
- ☐ McKesson Pharmacy Services
- ☐ Rx30
- ☐ NDC
- ☐ Other: _____

NCPDP/NABP Number: _____

Anticipated Date of Beginning Operations: _____

1. ☐ Yes ☐ No	I am the pharmacist-in-charge or consulting pharmacist of the above named facility.
2. ☐ Yes ☐ No	I will submit all required data regarding every prescription for a controlled substance dispensed in Utah by me and all pharmacists under my supervision to any person other than an inpatient in a licensed health care facility in accordance with the Section 58-37f-203.
3. ☐ Yes ☐ No	I have read and understand Section 58-37f-203 of the Utah Controlled Substances Act.

Signature of PIC/CP: _____ **Date:** _____

Note: *In addition to completing this questionnaire, you must complete the items listed on the OPTIONAL CONTROLLED SUBSTANCE LICENSE checklist at the end of this application.*

CLASS B PHARMACY INSPECTION REFERRAL

Pharmacy Name: _____ **Email:** _____

Pharmacy Address: _____
Street Address (including Apt/Unit/Ste #) *City* *State* *ZIP*

Pharmacy Telephone: _____ **Pharmacy Fax:** _____

PIC or CP: _____ **PIC/CP Telephone:** _____

PIC License # _____ **PIC Email:** _____

Local Contact Person: _____

Local Contact Telephone: _____ **Local Contact Email:** _____

Pharmacy Hours of Operation: _____

Parent Pharmacy ***(Branch Pharmacies Only)*** **:** _____

Parent Pharmacy License Number***(Branch Pharmacies Only)*** **:** _____

Will you engage in sterile or non-sterile compounding? ☐ Yes ☐ No

I understand that all entities licensed under Sections 58-17b-301 and 58-17b-302 shall comply with all state and federal laws and regulations relating to the practice of pharmacy, and that by making this application for licensure, attest to full compliance with said laws.

I acknowledge that whenever an applicable statute or rule requires or prohibits action by a pharmacy, the pharmacist-in-charge and the owner of the pharmacy shall be responsible for all activities of the pharmacy, regardless of the form of the business organization.

I understand that a conditional pharmacy license may be issued to this pharmacy pending inspection and verification of compliance with the operating standards that apply to the practice of pharmacy. The outcome of the inspection is necessary to determine whether all licensure requirements are met, and a conditional pharmacy license is not renewable. I acknowledge the division's authority to inspect the licensee's business premises pursuant to Section 58-17b-103.

I attest that the information contained in this application is truthful, correct and complete. I understand that it is unlawful and punishable as a Class A Misdemeanor to deal with DOPL or the Licensing Board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

Signature of PIC/CP: _____ **Date:** _____

For Official Use Only

License Number(s): _____ Conditional Expiration: _____

Licensing Specialist: _____ Date of Referral: _____

Reason for Application: _____ Subtype (*if applicable):* _____

Notes:

APPLICATION CHECKLIST AND INSTRUCTIONS

This checklist is for your convenience, you do not need to include it with your application.
NOTE: Incomplete applications will be denied.

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

ALL APPLICANTS

All applicants are required to submit following items to complete the application:

- ☐ $200.00 non-refundable application-processing fee, made payable to "DOPL".
- ☐ $80.00 non-refundable Fingerprint Processing fee ($40 each) for the PIC/CP and the PIC's Direct Supervisor or the On-Site Supervisor if no PIC is required by law.
  - **Please Note:** If the PIC is the Sole Owner, and has no direct supervisor, please include a copy of the company's organizational chart and only $40.00.
- ☐ 2 Fingerprints *each* for the PIC/CP and the PIC's Direct Supervisor or On-Site Supervisor to be used by DOPL for a fingerprint search through the files of the Utah Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigations (FBI).
  - **Please Note**: Fingerprint services are available, with no additional charge for DOPL applicants, at DOPL's office (160 E 300 S Salt Lake City) from 8:00am to 4:30pm. Applicants that arrive late in the day without leaving sufficient time to be processed may be turned away. **Valid government issued ID (ie US Driver's License, State ID, Passport or US Military ID) is required**. If you are unable to obtain fingerprints at DOPL's office, you must include two completed (2) blue fingerprint cards (Form FD-258) with your application.
  - **REVIEW OF YOUR FBI RECORD**: If you wish to challenge the accuracy of the information in your FBI record, you should contact the agency that contributed the information in question. You may also direct the challenge to the FBI, Criminal Justice Information Services (CJIS) Division, Attn. SCU, Mod. D-2, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will forward the challenge to the respective agency.
- ☐ Completed "Pharmacy Inspection Referral" on page 7 of this application.

OPTIONAL CONTROLLED SUBSTANCE LICENSE

If your practice will include dispensing controlled substances to any person other than an inpatient in a licensed health care facility, you must apply for a Utah Controlled Substance License by submitting the following:

- ☐ $100.00 non-refundable application-processing fee, made payable to "DOPL".
- ☐ Complete the "Utah Controlled Substance Law and Rule Affidavit" found on page 5 of this application.
- ☐ Completed "Controlled Substance Database Questionnaire" found on page 6 of this application

***NOTE:** In addition to the Utah Controlled Substance License, you must hold a valid Federal Drug Enforcement Administration (DEA) registration.

Submit the above items with your completed application to:

In person or via express delivery:
Division of Occupational and Professional Licensing
Heber M Wells Building, 1st Floor Lobby
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:
Division of Occupational and Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741

If you have questions, feel free to contact the Division via our direct email address, doplbureau3@utah.gov , or via the phone or fax listed below.