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|-----------------------------|
| <i>Official Use Only</i> |
| Number: _____ |
| Date Approved/Denied: _____ |
| Approved/Denied By: _____ |

Pharmacy- Class D Out of State Mail Order

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 Trust, Corporation, GP, LLC, LP and LLP applicants only.

UT Division of Corporation Registration Number*: _____ EIN: _____

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 Driver 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: _____ SSN or EIN: _____

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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you currently under investigation or is any disciplinary action pending against you now by any <i>local, state or federal licensing, enforcement or regulatory agency</i> ? |
| 4. <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever been declared by any court to be incompetent by reason of mental defect or disease and not restored? |
| 5. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No | Are you currently using or have you recently (<i>within 90 days</i>) used any drugs (<i>including recreational drugs</i>) without a valid prescription, the possession or distribution of which is unlawful under applicable state or federal laws? |
| 8. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you currently have any criminal action pending?* |
| 10. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?* |
| 12. <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever been incarcerated for any reason in any correctional facility (<i>domestic or foreign</i>) 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. If you are applying due to a change of any kind, please complete the surrender form on page 7.

- | | |
|---|--|
| <input type="checkbox"/> New Facility | Utah License Number: _____ |
| <input type="checkbox"/> Change of Name | Current Name: _____ Effective Date of Change: _____ |
| <input type="checkbox"/> Change of Location or Remodel | Utah License Number: _____ Current Address: _____ Proposed Date of Change: _____ |
| <input type="checkbox"/> Change of Ownership of Existing Pharmacy | Utah License Number: _____ Effective Date of Change: _____ |

CONTACT INFORMATION

Contact Person for Licensing Purposes: _____

Direct Phone Number: _____ Direct Email: _____

Address: _____

Street Address (including Apt/Unit/Ste #) and/or PO Box

City

State

ZIP Code

NOTE: The address of record for the license will be the **FACILITY** address listed on the first page of this application, and must be the address where the pharmacy is physically located.

PHARMACIST IN CHARGE

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: _____ Date: _____

PHARMACIST IN CHARGE SUPERVISOR

NOTE: In addition to completing this section, you must submit two completed fingerprint cards for the PIC's immediate 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: _____

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.

PHARMACY INFORMATION

For the purpose of this section, "state" refers to the state where the facility is physically located.

State of Licensure: _____ State License Number: _____

State Licensure Classification: _____ Date of last State inspection: _____

Patient Toll Free Contact Telephone Number: _____

Days and hours of availability for patient counseling: _____

Yes No The pharmacy provides each patient with written competent counseling.

Yes No The pharmacy provides each patient with a toll-free telephone number by which the patient may contact a competent pharmacist at the pharmacy during normal business hours to receive oral counseling.

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.

CLASS D CONTROLLED SUBSTANCE DATABASE QUESTIONNAIRE

To be completed by the pharmacist-in-charge of all facilities that dispense controlled substances to any person in Utah other than an inpatient in a licensed health care facility.

PIC: _____ **Email:** _____

Pharmacy Name: _____ **Email:** _____

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

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

Software Vender:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Foundation Systems (FSI) | <input type="checkbox"/> PDX |
| <input type="checkbox"/> McKesson Pharmacy Services | <input type="checkbox"/> Rx30 |
| <input type="checkbox"/> NDC | <input type="checkbox"/> Other: _____ |

NCPDP/NABP Number: _____

Anticipated Date of Beginning Operations: _____

1. Yes No I am the pharmacist-in-charge 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: _____ **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.

**BEFORE THE
DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING
DEPARTMENT OF COMMERCE OF THE STATE OF UTAH**

IN THE MATTER OF THE LICENSE(S) ISSUED TO: _____

PHARMACY LICENSE NUMBER: _____

CONTROLLED SUBSTANCE LICENSE NUMBER: _____

TO ACT AS A: _____ PHARMACY WITHIN THE STATE OF UTAH.
(License Classification)

LICENSEE and the **DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING** ("Division") of the Utah Department of Commerce, upon acceptance by the Division agree as follows:

1. Licensee hereby tenders its license as a _____ Pharmacy to the Division, informing the Division that it wishes to surrender it to the Division.

2. Licensee affirms that it is offering to surrender its license because of the closure of the Pharmacy on:

Month: _____ Day: _____ Year: _____

That such closure is due to a change in (*please check one*):

NAME LOCATION OWNERSHIP N/A (Specify) _____

3. Licensee admits the jurisdiction of the Division over it and over the subject matter of its request.

4. Licensee affirms that it is offering to surrender its license voluntarily of its own free will and choice without any undue inducement, coercion, or threat from any source, and that the only promises or understandings it has obtained from the Division regarding the surrender of its license are those contained in this Agreement.

5. This agreement is not a finding of unprofessional or unlawful conduct nor is it disciplinary action against the Licensee. The Division retains any jurisdiction to subsequently initiate disciplinary proceedings for any conduct the Licensee may have engaged in prior to the date of this agreement or may engage in subsequent to the date of this agreement.

6. Licensee understands that it will not receive any refund of license or renewal fees previously paid to the Division.

7. Licensee agrees to remove any type of pharmacy advertising which would constitute a violation of Utah Code Ann. § 58-17b-501 (3)(b).

8. Licensee affirms that notification to the Division and compliance has been made as required in Utah Administrative Code R156-17b-604 and Utah Code Annotated § 58-17b-614.

9. If the surrender of a license(s) by the Licensee is due to a name change, change in ownership or location which will take place subsequent to the issuance of a new license(s), the Licensee affirms that upon the Divisions issuance of the new license(s), the Licensee will within 10 days surrender to the Division the former license(s) by completing this form and submitting it to the Division.

10. Licensee affirms the original Pharmacy licenses are attached and included with this document.

11. The undersigned affirms that they have the authority to enter into this agreement on behalf of the Licensee.

Licensee Owner/Responsible Agent: _____ Date: _____

Printed Name: _____ Title: _____

APPLICATION CHECKLIST AND INSTRUCTION

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.

Class D pharmacy is defined as a pharmacy located outside of Utah that is authorized as a retail mail order pharmacy to compound or dispense a drug or dispense a device to the public under a prescription order.

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".
- \$70.00 non-refundable Fingerprint Processing fee (\$35 each) for the PIC and the PIC's Direct Supervisor.
 - **Please Note:** If the PIC is the Sole Owner, and has no direct supervisor, please include a copy of the company's organization chart and only \$35.00.
- 2 Fingerprints *each* for the PIC and the PIC's direct 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.
- Official verification from the Board of Pharmacy of the state where the pharmacy is physically located indicating licensure in good standing.
- Copy of a state inspection report from the Board of Pharmacy of the state where the pharmacy is physically located completed within the last year indicating compliance with laws and regulations for the facility.
- Copy of a current license for the Pharmacist-in-Charge

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 4 of this application.
- Completed "Utah 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.