

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

Pharmacy- Class E

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: _____

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

New Facility

Utah License Number: _____

Change of Name

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 E SUBTYPE

Please select the subtype that you are applying for:

- Analytical Laboratory
- Animal Euthanasia
- Animal Narcotic Detection Training
- Non Drug or Device Handling Central Order Processing
- Durable Medical Equipment
- Human Clinical Investigational Drug Research Facility
- Medical Gas Provider
- Third Party Logistics Provider
- Veterinarian Pharmaceutical Facility

RESPONSIBLE INDIVIDUAL

All Class E pharmacies are required to identify the on-site supervisor or director responsible for ensuring compliance with all laws, rules and regulations governing the practice of pharmacy.

NOTE: In addition to completing this section, you must submit two completed fingerprint cards for the responsible individual; 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 Individual: _____

Date _____

ALTERNATIVE RESPONSIBLE INDIVIDUAL

All Class E pharmacies are required to identify an alternative to the on-site supervisor or director responsible. This individual can be a supervisor, manager or owner of the facility and must have the authority to ensure compliance with the laws, rules and regulations governing the practice of pharmacy.

NOTE: In addition to completing this section, you must submit two completed fingerprint cards for the alternative responsible individual; 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 Individual: _____

Date _____

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.

DOPL • Heber M. Wells Building • 160 East 300 South • P.O. Box 146741, Salt Lake City, UT 84114-6741
www.dopl.utah.gov • telephone (801) 530-6628 • toll-free in Utah (866) 275-3675 • fax (801) 530-6511

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.

OUT OF STATE APPLICANTS

If your pharmacy is physically located outside of Utah, please complete the following section. For the purpose of this section, "state" refers to the state where the facility is physically located. If licensure is not required in your state, please include a certified letter from the state Board of Pharmacy indicating that your business is exempt from licensure.

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.

CLASS E CONTROLLED SUBSTANCE DATABASE QUESTIONNAIRE

To be completed by the pharmacist-in-charge of all Central Order Processing 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.

CLASS E PHARMACY INSPECTION REFERRAL

Pharmacy Name: _____ Email: _____

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

Pharmacy Telephone: _____ Pharmacy Fax: _____

Local Contact Person: _____

Local Contact Telephone: _____ Local Contact Email: _____

Pharmacy Hours of Operation: _____

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 Responsible Person: _____ Date: _____

For Official Use Only

License Number: _____ Conditional Expiration: _____

Licensing Specialist: _____ Date of Referral: _____

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 Responsible Individual and Alternative Individual.
- 2 Fingerprints each** for the Responsible Individual and Alternative Individual 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" found on page 7 of this application.
- If applying for an Analytical Laboratory, Animal Euthanasia, Animal Narcotic Detection Training or Human Clinical Investigational Drug Research Facility license, you must provide a complete list of all drugs that you are requesting authorization to have on site.

OUT OF STATE APPLICANTS

If your facility is located outside of Utah, in addition to the items listed above, you must submit:

- 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. If a state inspection is not available, please submit a written statement explaining why.
- Copy of a current license for the Pharmacist-in-Charge if a Central Order Processing Facility.

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 if you are a Central Order Processing Facility.

***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.

DOPL • Heber M. Wells Building • 160 East 300 South • P.O. Box 146741, Salt Lake City, UT 84114-6741
www.dopl.utah.gov • telephone (801) 530-6628 • toll-free in Utah (866) 275-3675 • fax (801) 530-6511