



State of Utah

DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING

160 East 300 South, P.O. Box 146741
Salt Lake City, Utah 84114-6741
Telephone (801) 530-6628
www.dopl.utah.gov

(Note: Microsoft Word users can fill in the blanks, print the form and save it for their records)

License(s) Applying For:

CLASS A:

Retail

CLASS B:

Branch

Closed Door

Hospice Facility

Hospital Clinic

Methadone Clinic

Nuclear

Pharmaceutical Administration Facility

Utah Controlled Substance License

CLASS C:

Pharmaceutical Wholesaler/Distributor

Pharmaceutical Wholesaler/Manufacturer

CLASS D:

Out-of-State Mail Order

Central Order Entry Pharmacy

CLASS E: Check all that apply

Analytical Laboratory

Clinical Research Facility

Durable Medical Equipment

Medical Gases

Other: (list type) _____

The business legal name is the name that will appear on the license, normally the name registered with the Utah Division of Corporations. If there is a fictitious business name (*doing business as*), list that name also, e.g., XYZ Corporation dba XYZ Pharmacy. If the applicant is not required to register with the Division of Corporations, it is the name of the pharmacy/facility where licensed activity is to be conducted. The physical location and mailing address is the actual location where licensed activity will be conducted and the address where DOPL will send all mail

Name of Pharmacy/Facility:		dba:	
Physical Location:			
City:		State:	ZIP:
Phone #:	FAX:	E-Mail:	

Contact Person for Licensing Purposes:			
Name:			
Mailing Address:			
City:		State:	ZIP:
Contact Persons Direct Phone #:	FAX:	E-Mail:	

DO NOT WRITE IN THIS SECTION - FOR DIVISION USE ONLY			
License/Certificate Number: _____			
Date License/Certificate Approved/Denied: ___/___/___ by _____			
Reason for Denial/Other Comments: _____			
<input type="checkbox"/> Owner background check completed: Total: _____ Number passed: _____ Number failed: _____ Bureau Manager Review: <input type="checkbox"/> QQ <input type="checkbox"/> Yes answers <input type="checkbox"/> Other <input type="checkbox"/> Approve <input type="checkbox"/> Deny Date _____			
Comments:			

Complete for all Pharmacy Owners as reflected in the Articles of Incorporation.

(Use additional sheets if necessary):

1.	Owner/Operator:	DOB:	Percentage of Ownership:
	Phone #:	Social Security Number:	
	Owner Address:	e-mail address:	
	City:	State:	ZIP:
2.	Owner/Operator:	DOB:	Percentage of Ownership:
	Phone #:	Social Security Number:	
	Owner Address:	e-mail address:	
	City:	State:	ZIP:
3.	Owner/Operator:	DOB:	Percentage of Ownership:
	Phone #:	Social Security Number:	
	Owner Address:	e-mail address:	
	City:	State:	ZIP:

Complete if a Partnership: (Use additional sheets if necessary)

1.	Name of Partner:	DOB:	Partners FEIN:
	Phone #:	Social Security Number:	
	Partner Address:	e-mail address:	
	City:	State:	ZIP:
2.	Name of Partner:	DOB:	Partners FEIN:
	Phone #:	Social Security Number:	
	Partner Address:	e-mail address:	
	City:	State:	ZIP:
3.	Name of Partner:	DOB:	Partners FEIN:
	Phone #:	Social Security Number:	
	Partner Address:	e-mail address:	
	City:	State:	ZIP:

Complete if a Corporation: (Use additional sheets if necessary)

1.	Corporate Name:	FEIN:	State of Incorporation:
	Name of Corporate Officer:	DOB: (if not publically traded)	
	Title of Corporate Officer:	Social Security Number: (if not publically traded)	
	Business Address:	Phone #:	
	City:	State:	ZIP:
2.	Corporate Name:	FEIN:	State of Incorporation:
	Name of Corporate Officer:	DOB: (if not publically traded)	
	Title of Corporate Officer:	Social Security Number: (if not publically traded)	
	Business Address:	Phone #:	
	City:	State:	ZIP:
3.	Corporate Name:	FEIN:	State of Incorporation:
	Name of Corporate Officer:	DOB: (if not publically traded)	
	Title of Corporate Officer:	Social Security Number: (if not publically traded)	
	Business Address:	Phone #:	
	City:	State:	ZIP:

If A Sole Proprietorship: (Use additional sheets if necessary)

1.	Full Name:	DOB:	Social Security Number:
	Business Address:	Phone #:	FEIN:
	City:	State:	ZIP:

AFFIDAVIT and RELEASE AUTHORIZATION

I am the applicant described and identified in this application for licensure, certification, or registration in the State of Utah.

I am qualified in all respects for the license, certificate, or registration for which I am applying in this application.

To the best of my knowledge, the information contained in the application and its supporting document(s) is free of fraud, misrepresentation, or omission of material fact.

To the best of my knowledge, the information contained in the application and its supporting document(s) is truthful, correct, and complete; and, discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Division of Occupational and Professional Licensing in conjunction with this application or its supporting documents meet the same standard as set forth above.

I understand that it is unlawful and punishable as a class A misdemeanor to apply for or obtain a license or to otherwise deal with the Division of Occupational and Professional Licensing or a licensing board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

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

I authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, 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 of Occupational and Professional Licensing to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

Signature of Responsible Party: _____

Date of Signature: ____/____/____

Printed Name of Responsible Party: _____

COMPLIANCE WITH UTAH LAWS AND RULES

All owners, officers, managers, pharmacists, and pharmacy technicians associated with or employed by the applicant understand that it is their continuing responsibility to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which you are applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

Name: _____ Signature: _____ Date: _____

REASON FOR APPLICATION: Check "Yes" or "No"		
<input type="checkbox"/> Yes <input type="checkbox"/> No	New Facility	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Change of Name	
	Name as Formerly Licensed:	
	Utah Pharmacy License Number:	Utah Controlled Substance License Number:
	Effective Date of Name Change:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Change of Location or Remodel	
	Utah Pharmacy License Number:	Utah Controlled Substance License Number:
	Old Address or Relocation within the Facility:	
	Proposed Date of Relocation or Remodeling:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Change of Ownership of Existing Pharmacy	
	Name as Formerly Licensed:	Effective Date of Ownership Change:
	Utah Pharmacy License Number:	Utah Controlled Substance License Number:

UTAH CONTROLLED SUBSTANCES LAW AND RULES EXAMINATION

This examination is not intended to be difficult. The purpose of the exam is to bring to your attention specific practice issues you need to know in order to avoid violating Utah statute as well as Utah law and rule. If you are uncertain about any of the questions listed below, please refer to the references listed in order to become familiar with Utah's controlled substance prescribing practices.

Utah Controlled Substances Act, 58-37 <http://dopl.utah.gov/laws/58-37.pdf>
Utah Controlled Substances Act Rule, R156-37 <http://dopl.utah.gov/laws/R156-37.pdf>

Answer "True" or "False" for each statement. Submit this completed examination with your application for licensure.

<input type="checkbox"/> True <input type="checkbox"/> False	1. A prescription for a schedule II controlled substance may be filled in a quantity not to exceed a 30 day supply.
<input type="checkbox"/> True <input type="checkbox"/> False	2. A prescription for a schedule III or IV controlled substance may be refilled 5 times within a six month period from the issue date of the prescription.
<input type="checkbox"/> True <input type="checkbox"/> False	3. All prescription orders must be signed in ink or indelible pencil to prevent anyone from altering a legitimate prescription.
<input type="checkbox"/> True <input type="checkbox"/> False	4. Licensed prescribing practitioners must make their controlled substance stock and records available to DOPL personnel for inspection during regular business hours.
<input type="checkbox"/> True <input type="checkbox"/> False	5. All records of purchasing, prescribing, and administering controlled substances must be maintained by the licensed prescribing practitioner for at least five years.
<input type="checkbox"/> True <input type="checkbox"/> False	6. The name, address, and DEA registration number of the prescribing practitioner, and the name, address and age of the patient are required to be included on the prescription for a controlled substance.
<input type="checkbox"/> True <input type="checkbox"/> False	7. A controlled substance is taken according to the prescriber's instructions. A refill may be dispensed after 80% of the medication has been consumed.
<input type="checkbox"/> True <input type="checkbox"/> False	8. After the discovery of any theft or loss of a controlled substance, the prescribing practitioner is required to file the appropriate forms with the DEA, report the incident to the local police, and send copies of the filed DEA forms to DOPL.
<input type="checkbox"/> True <input type="checkbox"/> False	9. The maximum number of controlled substances that can be written on a single prescription form is one.
<input type="checkbox"/> True <input type="checkbox"/> False	10. An emergency verbal prescription order for a schedule II controlled substance requires that the patient be under the continuing care of the prescribing practitioner for a chronic disease, the amount of drug prescribed is limited to what is needed to adequately treat the patient for no more than 72 hours, and a written prescription shall be delivered to the filling pharmacy within 7 working days of the verbal order.
<input type="checkbox"/> True <input type="checkbox"/> False	11. Issuing a prescription for a schedule II or III controlled substance for yourself is considered unprofessional conduct and may result in disciplinary action.
<input type="checkbox"/> True <input type="checkbox"/> False	12. A prescribing practitioner is using a schedule IV controlled substance in the treatment of weight reduction for obesity. The practitioner has completed a medical history of the patient, has performed a complete physical examination, has ruled out contra-indications, and has determined that the health benefits of treatment greatly out-weigh the risks. An informed consent signed by the patient is also required prior to initiating treatment.
<input type="checkbox"/> True <input type="checkbox"/> False	13. The Division will immediately suspend the Utah controlled substance license if the DEA registration is denied, revoked, surrendered, or suspended.

PHARMACY QUALIFYING QUESTIONNAIRE

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

(Note: If you have formally expunged a criminal record you do not need to disclose that criminal history.)

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Have you ever applied for or received a license, certificate, permit, or registration to practice in a regulated profession under any name other than the name listed on this application?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant 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?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever been permitted to resign or surrender a license, certificate, permit, or registration to practice in a regulated profession while under investigation or while action was pending by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Is any facility, owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant currently under investigation or is any disciplinary action pending against such now by any licensing agency or governmental agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever had hospital or other health care facility privileges denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever been permitted to resign or surrender hospital or other health care facility privileges, while under investigation or while action was pending by any licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Is any action related to the conduct or patient care of any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant pending at any hospital or health care facility?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever had rights to participate in Medicaid, Medicare, or any other state or federal health care payment reimbursement program denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever been permitted to resign from Medicaid, Medicare, or any other state or federal health care payment reimbursement program while under investigation or while action was pending by any licensing agency, hospital, or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Is any action pending against any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant by Medicaid, Medicare, or any other state or federal health care payment reimbursement program?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever had a federal or state registration to sell, possess, prescribe, dispense, or administer controlled substances denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by either the federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever been permitted to surrender a registration to sell, possess, prescribe, dispense, or administer controlled substances while under investigation or while action was pending by any health care profession licensing agency, hospital or other health care facility, or criminal or administrative jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Is any action now pending against any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant by either the Federal Drug Enforcement Administration or any state drug enforcement agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant been named as a defendant in a malpractice suit?
<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitations, restrictions, or conditions imposed by any malpractice carrier?
<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever had any malpractice insurance coverage denied, conditioned, curtailed, limited, suspended, or revoked in any way?
<input type="checkbox"/> Yes <input type="checkbox"/> No	17. If you are licensed in the occupation/profession for which you are applying, would any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant pose a direct threat to himself, to your patients or clients, or to the public health, safety, or welfare because of any circumstance or condition?
<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever been declared by any court of competent jurisdiction incompetent by reason of mental defect or disease and not restored?
<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever been terminated from a position because of drug use or abuse?

<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Is any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant currently using or has any 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 the Utah Controlled Substances Act or other applicable state or federal law?
<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever used any drugs without a valid prescription, the possession or distribution of which is unlawful under the Utah Controlled Substances Act or other applicable state or federal law, for which he has not successfully completed or is not now participating in a supervised drug rehabilitation program, or for which he has not otherwise been successfully rehabilitated?
<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Has any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant ever had a documented case in which he was involved as the abuser in any incident of verbal, physical, mental, or sexual abuse?
<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Do you currently have any criminal action pending?
<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Have you ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	25. Have you ever been incarcerated for any reason in any federal, state or county correctional facility or in any correctional facility in any other jurisdiction or on probation/parole in any jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	26. 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? Motor vehicle offenses such as driving while impaired or intoxicated must be disclosed but minor traffic offenses such as parking or speeding violations need not be listed.
<input type="checkbox"/> Yes <input type="checkbox"/> No	27. Have you, in the past ten (10) years, been allowed to plea guilty or no contest to any criminal charge that was later dismissed (<i>i.e. plea-in-abeyance or deferred sentence</i>)?
	<p>If you answered “yes” to questions 23, 24, 25, 26, or 27 above, you must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. You must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).</p> <p>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.</p> <p>If you have formally expunged a criminal record as evidenced by a court order signed by a judge, you do not need to disclose that criminal history. Expungement orders must be sent to the Bureau of Criminal Identification and the FBI to enable the expungement to be completed and the criminal history eliminated from the records.</p> <p>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.</p> <p>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.</p>

On the following pages, complete the **ONE** section that pertains to the type of facility for which you are seeking licensure.

CLASS A: RETAIL

Name of Pharmacist-In-Charge		
PIC Telephone Number:		Facility Tax ID (FEIN/ITIN):
State of Licensure:	Pharmacist License #:	Controlled Substance License #:

CLASS B: BRANCH, CLOSED DOOR, HOSPICE, HOSPITAL CLINIC, NUCLEAR

Name of Pharmacist-In-Charge	
Telephone Number:	Facility Tax ID (FEIN/ITIN):
Utah Pharmacist License #:	Utah Controlled Substance License #:

CLASS B: METHADONE CLINIC OR PHARMACEUTICAL ADMINISTRATION FACILITY

Name of Consulting Pharmacist	
Consulting Pharmacist Telephone Number:	Facility Tax ID (FEIN/ITIN):
Utah Pharmacist License #:	Utah Controlled Substance License #:

CLASS B: NUCLEAR PHARMACY

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the Pharmacist-In-Charge certified by the Board of Pharmaceutical Specialists in Nuclear Pharmacy or have equivalent classroom and laboratory training and experience as required by the Utah Radiation Control Rules?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the pharmacy have a current Utah Radioactive Materials License?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you applied for the Utah Radioactive Materials License? If yes date applied for: _____
Name of Pharmacist-In-Charge	
PIC Telephone Number:	
Facility Tax ID (FEIN/ITIN):	
Utah Pharmacist License #:	
Utah Controlled Substance License #:	
Please note:	
<ul style="list-style-type: none"> • A nuclear pharmacy preparing sterile compounds must follow the USP-NF Chapter 797 Compound for sterile preparations. • A nuclear pharmacy preparing medications for a specific person shall be licensed as a Class B - nuclear pharmacy if located in Utah, or as a Class D pharmacy if located outside of Utah. 	

CLASS B: BRANCH PHARMACY (To be completed by the pharmacist-in-charge of the parent pharmacy. Use additional sheets wherever necessary.)

Physical Address of the Branch Pharmacy:		
City:	State:	ZIP:
Telephone Number:	FAX:	
Identify the distance between or from all nearby alternative pharmacies and all other factors affecting access of persons in the area to alternative pharmacy resources.		
Describe the facility in which the branch pharmacy is to be located.		
STAFF: List all qualified persons (APRN, Physician, Osteopathic Physician, PA) who will staff and dispense prescription drugs at the branch pharmacy.		
Name	Position:	
License Classification:	License Number:	
Name	Position:	
License Classification:	License Number:	
Name	Position:	
License Classification:	License Number:	

PARENT PHARMACY FOR CLASS B BRANCH PHARMACY:			
Name of Parent Pharmacy:			
City:		State:	ZIP:
Pharmacy License #:		Controlled Substance License #:	
Name of Pharmacist-In-Charge			
City:		State:	ZIP:
Pharmacist License #:		Controlled Substance License #:	
PARENT PHARMACY SUPERVISING PHARMACIST WILLING TO ASSUME RESPONSIBILITY AS CONSULTING PHARMACIST FOR THE BRANCH PHARMACY:			
Name :			
Telephone Number:		Tax ID (FEIN/ITIN):	
Pharmacist License #:		Controlled Substance License #:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	A formulary of prescription drugs to be prepackaged, including name of drug, dosage strength, and dosage units, is included with this application.		
<input type="checkbox"/> Yes <input type="checkbox"/> No	A summary of operating protocol, including the conditions under which the drugs will be stored, used, and accounted for, is included with this application		
<input type="checkbox"/> Yes <input type="checkbox"/> No	A summary of the method by which drugs will be transported from the parent pharmacy to the branch pharmacy and accounted for by the branch pharmacy, is included with this application.		
<input type="checkbox"/> Yes <input type="checkbox"/> No	A description of how records will be kept and audits and inventories dealt with in regard to: the formulary, drugs sent and received, drugs dispensed, frequency and method of inventories and controls, is included with this application.		

CLASS C: PHARMACEUTICAL WHOLESALER, DISTRIBUTOR, OR MANUFACTURER			
Facility Address:			
City:		State:	ZIP:
List All Trade or Business Names Used:			
FDA Number (manufactures only):		Tax ID (FEIN/ITIN):	
Complete for the Designated Representative for Each Facility. (Use additional sheets if necessary):			
1.	Designated Representative:		DOB:
	Social Security #:		DOB:
	Facility Address:		Phone #:
	City:		State:
List at least three years experience in the manufacture or distribution of prescription drugs, including controlled substances. (Use additional sheets if necessary.)			
2.	Designated Representative:		DOB:
	Social Security #:		DOB:
	Facility Address:		Phone #:
	City:		State:
List at least three years experience in the manufacture or distribution of prescription drugs, including controlled substances. (Use additional sheets if necessary.)			

CLASS D: OUT-OF-STATE MAIL ORDER, OUT-OF-STATE NUCLEAR**Please note:**

- A nuclear pharmacy preparing medications for a specific person shall be licensed as a Class D if located outside of Utah. A Nuclear pharmacy preparing sterile compounds must follow the USP-NF Chapter 797 Compound for sterile preparations.

State in Which Facility is Located:

Pharmacy License Number:

Tax ID (FEIN/ITIN):

Category or Classification of License:

Name of Pharmacist in Charge:

License Number:

Date of Last Inspection by Licensing Authority:

Patient Toll Free Contact Telephone Number:

Availability for Patient Counseling:

Days:

Hours:

 Yes NoA certified letter from the licensing authority of the state in which the pharmacy is located attesting to the fact that the pharmacy is licensed in good standing and is in compliance with all laws and regulations of that state, is **included with this application**. Yes NoA copy of the Pharmacist in charge current license is **attached**. Yes NoA copy of the most recent state inspection showing the status of compliance with laws and regulations for physical facility, records, and operations, is **included with this application**. 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.

AFFIDAVIT

I, _____, affirm that _____ Pharmacy will cooperate with all lawful requests and directions of the licensing authority of the state of domicile relating to the shipment, mailing, or delivery of dispensed legend drugs into Utah.

Signature: _____ Date: ___/___/___

CLASS E: ANALYTICAL LABORATORY

Laboratory Director Name:

Address:

City:

State:

ZIP:

Telephone Number:

Tax ID (FEIN/ITIN):

PROTOCOL: Describe how prescription drugs will be purchased, stored, used, and accounted for. *(Use additional sheets if necessary.)*

CLASS E: MEDICAL GASES

Contact Person:

Facility Name:

Address:

City:

State:

ZIP:

Telephone Number:

Social Security Number:

List past experience in the working with the storage and handling of medical gases. *(Use additional sheets if necessary.)*

CLASS E: DURABLE MEDICAL EQUIPMENT:

Please note: Section 58-17b-102 of the Pharmacy Practice Act reads: (62) "Prescription device" means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, and any component part or accessory, which is required under federal or state law to be prescribed by a practitioner and dispensed by or through a person or entity licensed under this chapter or exempt from licensure under this chapter.

Contact Person:	Social Security Number:	
Facility Name:		
Address:		
City:	State:	ZIP:
Telephone Number:	Tax ID (FEIN/ITIN):	

PROTOCOL: Describe where durable medical equipment will be stored, used, and accounted for. *(Use additional sheets if necessary.)*

<input type="checkbox"/> Yes <input type="checkbox"/> No	A certified letter from the licensing authority of the state in which the business is located attesting to the fact that the business is licensed in good standing and is in compliance with all laws and regulations of that state is included with this application or has been requested to be sent directly to the Division, or
<input type="checkbox"/> Yes <input type="checkbox"/> No	A certified letter from the licensing authority indicating a license is not required is included with this application, or has been requested to be sent directly to the Division.

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CONTROLLED SUBSTANCE DATABASE QUESTIONNAIRE

To Be Completed By The Pharmacist-In-Charge Of All In-State and Out-Of-State Pharmaceutical Facilities that Dispense Controlled Substances in Utah to any person other than an inpatient in a licensed health care facility.

Pharmacist-In-Charge:	E-Mail:
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Pharmacy Name:

Pharmacy Address:	E-Mail:
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Telephone:	Fax:
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Type of Pharmacy: CLASS A: <input type="checkbox"/> Retail CLASS B: <input type="checkbox"/> Branch <input type="checkbox"/> Closed Door <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Hospital Clinic <input type="checkbox"/> Nuclear <input type="checkbox"/> Pharmaceutical Administration Facility	CLASS D: <input type="checkbox"/> Out-of-State Mail Order <input type="checkbox"/> Central Order Entry Pharmacy
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Software Vendor:

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

NCPDP/NABP Number:

Anticipated Date of Beginning Operation:
--

Check "Yes" or "No."

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | I am the pharmacist-in-charge of the above named pharmaceutical facility. |
| <input type="checkbox"/> Yes <input type="checkbox"/> 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 Section 58-37f.203 of the Utah Controlled Substances Act. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | I have read and understand Section 58-37f-203 of the Utah Controlled Substances Act. |

Signature of Pharmacist-In-Charge:	Date:
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(FOR TWO-SIDED PRINTING)

**NEW OPENING - PHARMACY SELF-INSPECTION REPORT
CLASS "A" (RETAIL) PHARMACIES ONLY**

This report and Class "A" pharmacy application should not be submitted to DOPL until the facility is substantially completed and is within six weeks of the anticipated date of opening.

Pharmacy Name:			Report Date:		
Mailing Address:					
City:				State:	ZIP:
Phone #:		Pharmacy FAX #:		E-Mail:	
Pharmacy Hours of Operation:	Monday-Friday:		Saturday:		Sunday:
DOPL Pharmacy License Number:				Expiration Date:	
DOPL Controlled Substance License Number:				Expiration Date:	
DEA Registration Number:				Expiration Date:	
List ALL Pharmacists, Interns and Pharmacy Technicians. <i>(Attach a separate sheet, if necessary.)</i>					
Pharmacist-in-Charge:		License Number:		Expiration Date:	
Name:		License Number:		Expiration Date:	
Name:		License Number:		Expiration Date:	
Name:		License Number:		Expiration Date:	
Name:		License Number:		Expiration Date:	
Name:		License Number:		Expiration Date:	
Name:		License Number:		Expiration Date:	
Name:		License Number:		Expiration Date:	
Name:		License Number:		Expiration Date:	
Name:		License Number:		Expiration Date:	
Name:		License Number:		Expiration Date:	
List ALL Technicians-in-Training. <i>(Attach a separate sheet, if necessary.)</i>					
Name:				Program Start Date:	
Name:				Program Start Date:	
Name:				Program Start Date:	
Name:				Program Start Date:	
Name:				Program Start Date:	

CLASS A SELF ASSESSMENT QUESTIONNAIRE

Read thoroughly, and answer the questions as “Yes”, “No” or “N/A”. Only answer “N/A” if the question does not apply to your pharmacy. Do not leave any question blank.

For each “No” answer, provide an explanation on an attached sheet.

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	1. Pharmacy technicians, including no more than one pharmacy technician-in-training, shall be supervised on-site by a pharmacist. Pharmacy Practice Act Rule, R156-17b-601
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	2. The pharmacist-in-charge (PIC) is responsible for assuring that no pharmacy or pharmacist operates the pharmacy or allows operation of the pharmacy with a ratio of pharmacist to pharmacy technician/pharmacy intern/supportive personnel which, under the circumstances of the particular practice setting, results in, or reasonably would be expected to result in, an unreasonable risk of harm to public health, safety, and welfare. Pharmacy Practice Act Rule, R156-17b-603
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	3. If the facility has a pharmacy technician training program, the program has been granted approval by the Division in collaboration with the Board. Pharmacy Practice Act Rule, R156-17b-304
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	4. All individuals employed in a pharmacy facility having any contact with the public or patients receiving services from that pharmacy facility shall wear on their person a clearly visible and readable identification showing the individual’s name and position. Pharmacy Practice Act, 58-17b-603
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	5. Notification has been provided to the Division in regards to the assignment of the PIC at the above stated pharmacy. Pharmacy Practice Act Rule, R156-17b-603
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	6. When communicating by any means, written, verbal, or electronic, pharmacy personnel must identify themselves as to licensure classification. Pharmacy Practice Act, 58-17b-603
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	7. Every pharmacy facility shall orally offer to counsel a patient or a patient’s agent in a personal face-to-face discussion with respect to each prescription drug dispensed... A pharmacist or pharmacy intern shall provide counseling to each patient. Pharmacy Practice Act, 58-17b-613
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	8. The offer to counsel shall be documented and said documentation shall be available to the Division. Pharmacy Practice Act Rule, R156-17b-610
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	9. Facilities shall have a counseling area to allow for confidential patient counseling, where applicable. Pharmacy Practice Act Rule, R156-17b-614a
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	10. The facility shall be well lighted, ventilated, clean and sanitary. Pharmacy Practice Act Rule, R156-17b-614a
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	11. The dispensing area shall have a sink with hot and cold culinary water separate and apart from any restroom facilities. Pharmacy Practice Act Rule, R156-17b-614a
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	12. The facility shall be equipped to permit the orderly storage of prescription drugs and devices in a manner to permit clear identification, separation and easy retrieval of products and an environment necessary to maintain the integrity of the product inventory. Pharmacy Practice Act Rule, R156-17b-614a
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	13. The facility shall be stocked with the quality and quantity of product necessary for the facility to meet its scope of practice in a manner consistent with the public health, safety and welfare. Pharmacy Practice Act Rule, R156-17b-614a
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	14. The facility shall be equipped with a security system to permit detection of entry at all times when the facility is closed. Pharmacy Practice Act Rule, R156-17b-614a
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	15. The facility is engaged in extensive compounding activities. If you answer “yes” to this question, a compounding questionnaire must be completed. Pharmacy Practice Act Rule, R156-17b-614a
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	16. The temperature of the pharmacy shall be maintained within a range compatible with the proper storage of the drugs. Documentation verifying temperature compliance shall be available to the Division upon request. Pharmacy Practice Act Rule, R156-17b-614a
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	17. The temperature of the refrigerator and freezer shall be maintained within a range compatible with the proper storage of drugs requiring refrigeration or freezing. Documentation verifying temperature compliance shall be available to the Division upon request. Pharmacy Practice Act Rule, R156-17b-614a
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	18. The facility shall post the license of the facility and the license or a copy of the license of each pharmacist, pharmacy intern and pharmacy technician who is employed in the facility, but may not post the license of any just stated employee not actually employed in the facility. Pharmacy Practice Act Rule, R156-17b-614a
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	19. The facility shall have current and retrievable editions of the following reference publications in print or electronic format and readily available and retrievable to facility personnel: Pharmacy Practice Act Rule, R156-17b-614a <ul style="list-style-type: none"> • DOPL Licensing Act, 58-1 • Pharmacy Practice Act, 58-17b • Utah Controlled Substances Act, 58-37 • Code of Federal Regulations – CRF Title 21 • General Rule for DOPL, R156-1 • Pharmacy Practice Act Rule, R156-17b • Utah Controlled Substance Act Rule, R156-37 • FDA – Orange Book: Approved Drug Products

	<ul style="list-style-type: none"> • General Drug References
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	20. If the pharmacy is located within a larger facility such as a grocery or department store, and a licensed Utah pharmacist is not immediately available in the facility, the pharmacy shall not remain open to pharmacy patients and shall be locked in such a way as to bar entry to the public or any non-pharmacy personnel. All pharmacies located within a larger facility shall be locked and enclosed in such a way as to bar entry by the public or any non-pharmacy personnel when the pharmacy is closed. Pharmacy Practice Act Rule, R156-17b-614a
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	21. Only a licensed Utah pharmacist or authorized pharmacy personnel shall have access to the pharmacy when the pharmacy is closed. Pharmacy Practice Act Rule, R156-17b-614a
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	22. The facility shall maintain a permanent log of the initials or identification codes which identify each dispensing pharmacist by name. The initials or identification codes shall be unique to ensure that each pharmacist can be identified. Pharmacy Practice Act Rule, R156-17b-614a
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	23. Prescription files, including refill information, shall be maintained for a minimum of five years and should be immediately retrievable in written or electronic format. Pharmacy Practice Act Rule, R156-17b-612
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	24. An annual inventory shall be conducted every 12 months, following the inventory date of each year and may be taken within four days of the specified inventory date. The PIC is responsible for meeting all inventory requirements. Inventory records shall be filed separately from all other records and must be maintained for a period of five years and be readily available for inspection. Pharmacy Practice Act Rule, R156-17b-605
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	25. Unless otherwise requested, child-resistant containers are used for dispensing medications to patients. 16 CFR 1700 – Poison Prevention Packaging
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	26. Each drug dispensed from the pharmacy shall have a label securely affixed to the container indicating the required minimum information, including: Pharmacy Practice Act, 58-17b-602 <ul style="list-style-type: none"> • Name, Address, & Phone Number of Pharmacy • Serial Number of Prescription • Filling Date or Last Dispensing Date • Name of the Patient or Animal Owner / Species • Name of the Prescriber • Directions For Use & Cautionary Statements • Trade, Generic or Chemical Name • Amount Dispensed & Strength of Dosage Form • Beyond Use Date <i>(Unless Otherwise Indicated by Prescriber)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	27. Prescription records may be maintained electronically so long as the original of each prescription, including telephone prescriptions, is maintained in a physical file and contains all of the information required by federal and state law; and an automated data processing system is used for the storage and immediate retrieval of refill information for prescription orders. Utah Controlled Substance Act Rule, R156-37-602
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	28. Prescription forms and records of all controlled substances listed in Schedule II are maintained separately from Schedules III through V, which are maintained separately from all other facility records. Records must be maintained by licensee for a period of five (5) years. Utah Controlled Substance Act Rule, R156-37-602
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	29. The registered pharmacy only processes electronically signed prescriptions for controlled substances under the following conditions: the pharmacy uses a pharmacy application that meets all the applicable requirements; the prescription is otherwise in conformity with the requirements of the Code of Federal Regulations; and Certification Authority (CA) has been obtained. The electronic prescription must be transmitted from the practitioner to the pharmacy in its electronic form and at no time may the prescription be converted to another form (<i>i.e. facsimile</i>) for transmission. 21 CFR 1311 – Requirement for Electronic Orders and Prescriptions
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	30. The PIC shall, for each controlled substance dispensed by a pharmacist under the PIC's supervision...submit to the division ...positive identification of the individual receiving the prescription, including the type of identification and any identifying numbers on the identification. Controlled Substance Database Act, 58-37f-203
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	31. Controlled substance data collection is submitted to the Controlled Substance Database, as required, at least once a week. Utah Controlled Substance Act Rule, R156-37-609
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	32. Any facility who experiences a shortage or theft of controlled substances shall immediately file the appropriate forms with the Drug Enforcement Administration, with a copy to the Division directed to the attention of the Investigation Bureau. Utah Controlled Substance Act Rule, R156-37-602
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	33. The pharmacy does not dispense legend drugs or controlled substances that have been issued by an online prescriber as part of an Internet facilitator arrangement, unless as otherwise allowed for pursuant to Utah Code Annotated, Title 58, Chapter 83. Online Prescribing, Dispensing, and Facilitation Licensing Act, 58-83-501 and 503
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	34. Except when delivered to the ultimate user via the United States Postal Service, licensed common carrier, or supportive personnel, prescription drugs are only dispensed to the ultimate user or his agent directly from the pharmacy. Pharmacy Practice Act, 58-17b-602

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	35. The pharmacy does not accept back and redistribute any unused drug, or part of it unless otherwise allowed for pursuant to Section 58-17b-503. Pharmacy Practice Act, 58-17b-503 and 502
Comments:	

I attest that the information contained in this “Pharmacy Self-Inspection Report” 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 Pharmacist-in-Charge: <i>(if submitting electronically, type “ACKNOWLEDGED” followed by your full name)</i>	
Printed Name of Pharmacist-in-Charge:	Date of Signature:

Application Instructions and Information

Mandatory Attachment Checklist <i>(Applications with incomplete attachments will not be considered and may be denied.)</i>	
<input type="checkbox"/>	Submit a complete DOPL application form to the DOPL address below.
<input type="checkbox"/>	Submit Appropriate Application Fees <input type="checkbox"/> Pharmacy <i>(\$200.00 Non Refundable Application Fee)</i> <input type="checkbox"/> Controlled Substance <i>(\$100.00 Non Refundable Application Fee)</i> if the pharmacy will be dispensing controlled substances within or into Utah. <i>NOTE: If you are applying for a pharmaceutical license and a controlled substance license, you can pay the \$300.00 fees in a single check or money order. You can also include in the single check or money order the additional \$40.00 BCI/FBI fee for each owner.</i> <input type="checkbox"/> BCI/FBI fee for each owner listed (\$40.00) *See important additional information.
<input type="checkbox"/>	For ALL Pharmacy Owners as listed on the Articles of Incorporation (if not publically traded): <input type="checkbox"/> Submit three applicant fingerprint cards (Form FD-258: white with blue lines) to be used by DOPL for a search through the files of the Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigation (FBI) for each pharmacy owner. <input type="checkbox"/> Attach Articles of Incorporation.
<input type="checkbox"/>	Submit the completed "Controlled Substance Database Questionnaire" if the facility seeking licensure intends to dispense controlled substances in Utah to any person other than an inpatient in a licensed health care facility. This requirement applies to both in-state and out-of-state facilities.
<input type="checkbox"/>	Class A, retail pharmacy: <input type="checkbox"/> Complete the "New Opening Pharmacy Self-Inspection Report for Class A (Retail) Pharmacy."
<input type="checkbox"/>	Class B, branch pharmacy: Attach the following documents: <input type="checkbox"/> A formulary of prescription drugs to be prepackaged, including name of drug, dosage strength and dosage units. <input type="checkbox"/> A summary of the operating protocol, including the conditions under which the drugs will be stored, used, and accounted for. <input type="checkbox"/> A summary of the method by which drugs will be transported from the parent pharmacy to the branch pharmacy and accounted for by the branch pharmacy. <input type="checkbox"/> A description of how your records will be kept and audits and inventories dealt with in regard to the formulary, drugs sent and received, drugs dispensed, frequency and method of inventories and controls.
<input type="checkbox"/>	Class D, out-of-state mail order pharmacy: Attach the following documents: <input type="checkbox"/> Certified letter from the licensing authority of the state in which the pharmacy is located attesting to the fact that the pharmacy is licensed in good standing and is in compliance with all laws and regulations of that state. <input type="checkbox"/> A copy of the most recent state inspection showing the status of compliance with laws and regulations for physical facility, records and operations. <input type="checkbox"/> A copy of a current license for the Pharmacist-in-Charge.
<input type="checkbox"/>	Class E: Attach the following documents: <input type="checkbox"/> A certified letter from the licensing authority of the state in which the business is located attesting to the fact that the business is licensed in good standing and is in compliance with all laws and regulations of that state, or <input type="checkbox"/> A certified letter from the licensing authority indicating a license is not required. <input type="checkbox"/> A copy of the most recent state inspection showing the status of compliance with laws and regulations for physical facility, records and operations.

The Pharmacy must hold a Utah dispensing controlled substance license and a Drug Enforcement Administration (DEA) registration to dispense a controlled substance in Utah. **Contact the DEA at Salt Lake District Office 348 East South Temple Salt Lake City UT 84088. Telephone (801) 524-4389.**

***Additional Important Information:**

1. **Address of Record:** The address provided on this application **MUST** be the address where the pharmacy is physically located. The Division is required to mail the license and all correspondence to the physical address of the pharmacy. If the pharmacy changes addresses, a **NEW APPLICATION** must be submitted and the old license surrendered to the Division.
2. **Laws and Rules:** You are required to understand Utah laws and rules pertaining to your practice. The following laws and rules are available on the Internet at www.dopl.utah.gov.
 - Division of Occupational & Professional Licensing Act
 - General Rules of the Division of Occupational & Professional Licensing
 - Pharmacy Practice Act
 - Pharmacy Practice Act Rules
 - Utah Controlled Substances Act
 - Utah Controlled Substances Act Rules
 - Utah Controlled Substance Database Act

3. **Fingerprint Information:** All pharmacy owners are required to undergo a criminal background check and fingerprint search through the files of the Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigation (FBI). *Fingerprint cards that are not complete and/or properly rolled will be rejected, delaying the licensure process.* To expedite the licensure process, you can obtain electronic fingerprinting at DOPL's offices (160 E. 300 S., Salt Lake City), 8:00 a.m. to 4:30 p.m., Monday through Friday, except holidays. Currently, there is no fee to roll electronic fingerprints for DOPL licensure applicants. A current government issued picture ID is required. If you are unable to obtain electronic fingerprints at DOPL's office, you must include three (3) blue fingerprint cards (Form FD-258) with your application. Fingerprint cards are supplied with the application if obtained from DOPL. If you downloaded the application from the Internet, you may obtain fingerprint cards from DOPL, the Bureau of Criminal Identification (BCI), or your local police station.
4. **License Renewal:** All pharmacy licenses expire September 30 of each odd-numbered year. Your pharmacy controlled substance license will expire at the same time as the pharmacy license and will also need to be renewed. Each licensee is responsible to renew the license PRIOR to the expiration date shown on the current license. Approximately two months prior to the expiration date shown on the license, renewal information is disseminated to each licensee's address of record, as provided to DOPL.
5. **Name, Location, or Ownership Change:** If you change the name of your agency, if its location changes, or if there is a change in ownership, you must submit a new application and new licensure fees.
6. **Patient Counseling:** A pharmacist or pharmacy intern in a retail pharmacy, out-of-state mail order pharmacy, or institutional pharmacy shall orally offer to counsel a patient or a patient's agent in a personal face-to-face discussion with respect to each prescription drug dispensed, if the patient or patient's agent:
 - Delivers the prescription in person to the pharmacist, pharmacy intern, or pharmacy technician with instructions that the dispensed prescription drug be mailed or otherwise delivered to the patient outside of the pharmaceutical facility or
 - Receives the drug in person at the time it is dispensed at the pharmaceutical facility.
 A pharmacist or pharmacy intern in a retail pharmacy, out-of-state mail service pharmacy, or institutional pharmacy shall provide each patient, in writing, competent counseling, and shall provide the patient with a toll-free telephone number by which the patient may contact a competent pharmacist at the dispensing pharmacy during normal business hours and receive oral counseling, with respect to each prescription drug dispensed if the patient provides or the prescriptions otherwise provided to the pharmaceutical facility by a means other than personal delivery, and the dispensed prescription drug is mailed or otherwise delivered to the patient outside of the pharmaceutical facility.
7. **Pharmacy Inspection:** As a requirement for licensure, all in-state facilities must pass an inspection. DOPL will schedule an inspection of the facility. All out-of-state mail order pharmacies must include a copy of the most recent inspection conducted by the state in which the dispensing facility is located.
8. **Social Security Number:** Your social security number is classified as a private record under the Utah Government Records Access and Management Act. If an SSN is not provided, the application is incomplete and may be denied.
9. **Tax ID (FEIN/ITN):** Attach proof of registration in the State where the pharmacy is located. If located within Utah, contact the Utah Department of Corporation and Commercial Code. Their web site is www.corporations.utah.gov.
10. **Wholesaler/Distributor:** Utah licensure is required if drugs are stored in or distributed from any facility physically located in Utah. If there are no facilities in Utah, but drugs are shipped into Utah, licensure, in good standing, is required in the state of domicile, but Utah licensure is not required unless shipping directly to the end user (patient).
11. **Acceptable Forms of Payment:** Licensure fees can be paid by check or money order, made payable to "DOPL." Cash and debit/credit cards (*American Express, MasterCard, and Visa*) are also accepted in person at DOPL's main office – but not over the telephone.
12. **Mail Complete Application to:**
 - By U.S. Mail*
 - Division of Occupational & Professional Licensing
 - P.O. Box 146741
 - Salt Lake City, Utah 84114-6741
 - By Delivery or Express Mail*
 - Division of Occupational & Professional Licensing
 - 160 East 300 South, 1st Floor Lobby
 - Salt Lake City, Utah 84111
13. **Telephone Numbers:**
 - (801) 530-6628
 - (866) 275-3675 – Toll-free in Utah