

**STATE OF UTAH**  
**DIVISION OF OCCUPATIONAL AND PROFESSIONAL LICENSING**

**APPLICATION FOR LICENSURE**  
**PHARMACY – ALL CLASSIFICATIONS**

**APPLICATION INSTRUCTIONS AND INFORMATION:**

**General Statement:** The Utah Division of Occupational and Professional Licensing (DOPL) desires to provide courteous and timely service to all applicants for licensure. To facilitate the application process, **submit a complete application form including all applicable supporting documents and fees.** Failure to submit a complete application and supply all necessary information will delay processing and may result in denial of licensure. The fees are for processing your application and will not be refunded. **Please read all instructions carefully.**

**Business Legal Name of Pharmacy/Facility:** 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., ABC Corporation dba XYZ Pharmacy. If the applicant is not required to register with the Utah Division of Corporations, it is the name of the pharmacy/facility where licensed activity is to be conducted. See Utah Division of Corporations and Commercial Code, 42-2-5(2).

**Registration with the Utah Division of Corporations and Commercial Code:** Prior to licensing, the business entity is to be registered with the Utah Division of Corporations. A sole proprietorship is not required to register with the Utah Division of Corporations. When an applicant is a sole proprietor the license will be issued in the individual’s name. A DBA (Doing Business As) may be noted on the application and added to a license; however, the DBA must first be registered with Corporations. Corporation registration forms are available at [www.corporations.utah.gov](http://www.corporations.utah.gov).

**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.

**Social Security Number:** A social security number is classified as a private record under the Utah Government Records Access and Management Act. It is used by DOPL as an individual identifier. It is also used for child support enforcement pursuant to Subsection 78-32-17(3) and is mandatory pursuant to Subsection 58-1-301(1), Utah Code Ann., which implements 42 U.S.C. 666(a) (13). If a Social Security Number is not provided, the application is incomplete and may be denied.

**APPLICATION INSTRUCTIONS:**

<b>Mandatory Attachment Checklist</b> ( <i>Applications with incomplete attachments will not be considered and may be denied.</i> )	
<input type="checkbox"/>	Submit a complete Division of Occupational Licensing (DOPL) application form to the DOPL address below.
<input type="checkbox"/>	Submit Appropriate Application Fees <ul style="list-style-type: none"> <li><input type="checkbox"/> Pharmacy: <b>\$200.00 Non-Refundable Application Fee</b></li> <li><input type="checkbox"/> Controlled Substance: <b>\$100.00 Non-Refundable Application Fee</b> if the pharmacy will be dispensing controlled substances within or into Utah.</li> <li><input type="checkbox"/> BCI/FBI fingerprint fee: <b>\$40.00 Non-Refundable fee</b> for <b>each</b> pharmacy/facility owner, officer, director, partner, proprietor, pharmacist-in-charge, pharmacist-in-charge supervisor, senior supervisor or key personnel/responsible management personnel having direct responsibility for managing the day to day operations of the pharmacy.  <i>*See Important Additional Information.</i></li> </ul> <p><b>NOTE:</b> <i>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 individual being fingerprinted.</i></p>
<input type="checkbox"/>	<p><b>For Each</b> Pharmacy/Facility owner, officer, director, partner, proprietor, pharmacist-in-charge, pharmacist-in-charge supervisor, most senior supervisor or key personnel/responsible management personnel having direct responsibility for managing the day-to-day operations of the pharmacy.</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Submit <b>two</b> 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/facility owner.</li> </ul> <p>To help DOPL determine which individuals must be fingerprinted, please also include:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Articles of Incorporation, and</li> <li><input type="checkbox"/> Organizational Chart.</li> </ul>
<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"/>	The Pharmacy must hold a Utah dispensing controlled substance license <u>and</u> a Drug Enforcement Administration (DEA) registration to dispense a controlled substance in Utah. For the DEA registration, contact the DEA at Salt Lake District Office 348 East South Temple Salt Lake City UT 84088, telephone (801) 524-4389.
<input type="checkbox"/>	Class A, retail pharmacy. Class A pharmacy includes all retail operations located in Utah and requires a PIC: <ul style="list-style-type: none"> <li><input type="checkbox"/> Complete and submit the “New Opening Pharmacy Self-Inspection Report for Class A (Retail) Pharmacy.</li> </ul>
<input type="checkbox"/>	Class B, pharmacy. To qualify for licensure as a Class B pharmacy located in Utah, you must meet the following criteria: <ul style="list-style-type: none"> <li><input type="checkbox"/> Must be authorized to provide pharmaceutical care for a defined and exclusive group of patients who are either in an institutional setting or treated by or affiliated with a specific entity such as a health maintenance organization or an infusion company;</li> <li><input type="checkbox"/> Provide a physical environment for patients to obtain health care services unique to the needs of the target population; and</li> <li><input type="checkbox"/> Are either a methadone clinic; branch pharmacy; a pharmaceutical administration facility; a veterinarian pharmaceutical facility; or a sterile product preparation facility; or</li> <li><input type="checkbox"/> A closed door pharmacy that IS NOT affiliated with a hospital pharmacy, a retailer of goods to the general public, or the office of a practitioner.</li> <li><input type="checkbox"/> Employ a PIC full-time, as defined by the employer, unless a methadone clinic or pharmaceutical administration facility.</li> </ul> <p>In addition, if applying as a closed door pharmacy, submit the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> A narrative describing the specific group of patients that will receive pharmaceutical care and the affiliation with a specific entity.</li> </ul>
<input type="checkbox"/>	Class B, branch pharmacy: Please attach the following documents: <ul style="list-style-type: none"> <li><input type="checkbox"/> A formulary of prescription drugs to be prepackaged, including name of drug, dosage strength and dosage units.</li> <li><input type="checkbox"/> A summary of the operating protocol, including the conditions under which the drugs will be stored, used, and accounted for.</li> <li><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.</li> <li><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.</li> </ul>
<input type="checkbox"/>	Class B, nuclear pharmacy: <ul style="list-style-type: none"> <li><input type="checkbox"/> The Pharmacist-In-Charge must be certified by the Board of Pharmaceutical Specialists in Nuclear Pharmacy or have the equivalent classroom and laboratory training and experience as required by the Utah Radiation Control Rules. Please attach a copy of the Utah Radiation Control certificate.</li> <li><input type="checkbox"/> Please attach a copy of the current Utah Radioactive Materials License.</li> </ul> <p>Please note:</p> <ul style="list-style-type: none"> <li>• A nuclear pharmacy preparing sterile compounds must follow the USP-NF Chapter 797 Compound for sterile preparations.</li> <li>• 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.</li> </ul>
<input type="checkbox"/>	Class C, pharmaceutical wholesaler/distributor, pharmaceutical wholesale/manufacturer: <ul style="list-style-type: none"> <li><input type="checkbox"/> Submit a resumé for the designated representative for each facility.</li> <li><input type="checkbox"/> Submit a copy of the FDA registration.</li> </ul>
<input type="checkbox"/>	Class D, out-of-state mail order pharmacy: Attach the following documents: <ul style="list-style-type: none"> <li><input type="checkbox"/> 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.</li> <li><input type="checkbox"/> A copy of a recent state inspection report that has been completed within the last year indicating the status of compliance with laws and regulations for physical facility, records and operations.</li> <li><input type="checkbox"/> A copy of a current license for the Pharmacist-in-Charge.</li> <li><input type="checkbox"/> A copy of a current license for the Pharmacy.</li> </ul>
<input type="checkbox"/>	Class E, pharmacy: Attach the following documents: <ul style="list-style-type: none"> <li><input type="checkbox"/> A 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</li> </ul>

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|  | <ul style="list-style-type: none"> <li><input type="checkbox"/> A letter from the licensing authority indicating a license is not required.</li> <li><input type="checkbox"/> If licensed in the state of domicile, include a copy of the most recent state inspection showing the status of compliance with laws and regulations for physical facility, records and operations.</li> <li><input type="checkbox"/> A copy of a current Pharmacy license or registration.</li> <li><input type="checkbox"/> If applying as an Analytical Laboratory submit a written pharmacy care protocol which includes: <ul style="list-style-type: none"> <li>- The identity of the supervisor or director</li> <li>- A detailed plan of care</li> <li>- The identity of the drugs that will be purchased, stored, used and accounted for</li> <li>- And the identity of any licensed healthcare provider associated with operation</li> </ul> </li> </ul> |
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**\*Important Additional Important Information:**

1. **Application Processing:** Processing time for an application, *where the fingerprints have been electronically scanned by DOPL and there are no issues that need to be resolved*, is approximately 7 to 21 business days. Please allow additional time if an inspection is required. A pharmacy can not operate in Utah until the proper license(s) has been issued by DOPL.
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](http://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:** Submit fingerprints for all pharmacy/facility owners, officers, directors, partners, proprietors, pharmacists-in-charge, pharmacist-in-charge supervisor, senior supervisor, designated representative, key/management personnel having direct responsibility for managing the day-to-day operations of the pharmacy and shareholders unless the company is publicly listed and traded, 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 Investigation (FBI).

To expedite the licensure process, you can obtain electronic fingerprinting at DOPL’s office at 160 E. 300 S., Salt Lake City, 8:00 a.m. to 4:30 p.m., Monday through Friday, except holidays. The cost for having fingerprints electronically scanned by DOPL is covered in the \$40 non-refundable surcharge fee. Applicants that arrive late in the day without leaving sufficient time to be processed will be turned away. A current government issued picture ID is required. A current government issued picture identification can be one of the following: a driver’s license issued by Washington D.C., a state of the United States of America or an identification card issued by the state of Utah.

If you are unable to obtain electronic fingerprints at DOPL’s office, you must include two (2) blue fingerprint cards (Form FD-258) with your application for each individual associated with the application as defined above. **To have your fingerprints rolled onto the blue fingerprint cards, you must go to BCI, a local police station or an agency authorized by the FBI to roll fingerprints.** If you downloaded the application from the Internet, you may obtain fingerprint cards the Bureau of Criminal Identification (BCI), your local police station or authorized agency. *Fingerprint cards that are not complete and/or properly rolled will be rejected, delaying the licensure process.* **Due to the high number of inked fingerprint cards that are rejected and the amount of time it takes state and federal government agencies to process these cards, applicants are encouraged at the time of application to have their fingerprints electronically scanned at DOPL or at the Bureau of Criminal Identification.**

**Bureau of Criminal Identification (BCI) Information:**

- Check with BCI for pricing of their services
- Walk-ins only; no appointments taken
- Fingerprinting and Photo Services are available from 8:00 a.m. – 5:00 p.m., Monday - Friday except holidays
- Government-issued picture ID required (driver’s license, state ID, passport, etc.)
- Website: [www.bci.utah.gov](http://www.bci.utah.gov)
- Phone: (801) 965-4569
- Address: 3888 W. 5400 S., Taylorsville, UT 84118

**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.

4. **Name, Location, or Ownership Change:** If you change the name of your pharmacy/facility, change location, or if there is a change in ownership, you must submit a **NEW APPLICATION** including new licensure fees, fingerprints and all supporting documentation. A new license is also required if the business entity is dissolved by merging into a new partnership, corporation, or other business entity. In accordance with the Pharmacy Practice Act Rule, upon approval of the change in name, ownership or location, and upon the issuance of a new license, the original licenses shall be surrendered to the Division. A surrender form is attached to this application.
5. **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. Under Utah's renewal system, all licenses in each profession expire as a group on the same day every two years. Therefore, the length of a licensee's first renewal cycle depends on how far into the current renewal cycle initial licensure was obtained. Each renewal cycle thereafter is for a full two years. Additionally, the fee paid with this application for licensure is an application-processing fee only.
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. **Tax ID (FEIN/ITN):** You must list your Federal EIN (FEIN) or Federal Tax ID Number (TIN) on the application.
9. **State Tax ID:** You must list your State-Issued Tax ID Number on the application.
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. Utah licensure is not required under this circumstance 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. Credit card information is not accepted 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, 1<sup>st</sup> Floor Lobby  
Salt Lake City, Utah 84111

13. Telephone Numbers:  
(801) 530-6628  
(866) 275-3675 – Toll-free in Utah



# 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](http://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
- 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

**CLASS E: Check all that apply**

- Analytical Laboratory
- Animal Euthanasia
- Central Order Entry Processing
- Durable Medical Equipment
- Human Clinical Investigational Drug Research Facility
- Medical Gas Provider

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., ABC 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 correspondence.

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

Contact Person for Licensing Purposes: Name:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
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: \_\_\_\_\_

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Owner background check completed: Total: \_\_\_\_\_ Number passed: \_\_\_\_\_ Number failed: \_\_\_\_\_

Bureau Manager Review:  QQ  Yes answers  Other  Approve  Deny Date \_\_\_\_\_

Comments: \_\_\_\_\_

**Complete for all Pharmacy/Facility Owners:**

(Use additional sheets if necessary):

1.	Owner/Operator:		DOB:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
	Phone #:	E-Mail:	Social Security #:		% of Ownership:	
	Owner/Operator Address:			Drivers License # and State:		
	City:		State:		Zip Code:	
2.	Owner/Operator:		DOB:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
	Phone #:	E-Mail:	Social Security #:		% of Ownership:	
	Owner/Operator Address:			Drivers License # and State:		
	City:		State:		Zip Code:	
3.	Owner/Operator:		DOB:		<input type="checkbox"/> Male <input type="checkbox"/> Female	
	Phone #:	E-Mail:	Social Security #:		% of Ownership:	
	Owner/Operator Address:			Drivers License # and State:		
	City:		State:		Zip Code:	

**REASON FOR APPLICATION: Check "Yes" or "No"**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>New Facility:</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Change of Name:</b>
	Name as Formerly Licensed:
	Pharmacy License #: <span style="float: right;">Controlled Substance License #:</span>
	Effective Date of Name Change:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Change of Location or Remodel:</b>
	Pharmacy License #: <span style="float: right;">Controlled Substance License #:</span>
	Old Address or Relocation within the Facility:
	Proposed Date of Relocation or Remodeling:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Change of Ownership of Existing Pharmacy:</b>
	Name as Formerly Licensed: <span style="float: right;">Effective Date of Ownership Change:</span>
	Pharmacy License #: <span style="float: right;">Controlled Substance License #:</span>

**DISCLOSURE OF NATURE OF BUSINESS:** *(Please be specific. Use additional sheets if necessary.)*

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

1.	Name of Partner:		DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Phone #:	E-Mail:	Social Security #:	
	Partner Address:			Partners FEIN:
	City:		State:	ZIP:
2.	Name of Partner:		DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Phone #:	E-Mail:	Social Security #:	
	Partner Address:			Partners FEIN:
	City:		State:	ZIP:
3.	Name of Partner:		DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Phone #:	E-Mail:	Social Security #:	
	Partner Address:			Partners FEIN:
	City:		State:	ZIP:

**Complete if a Corporation:** List each officer and key/management personnel having direct responsibility for managing the day-to-day operations of the pharmacy. (Use additional sheets if necessary)

1.	Corporate Name:		FEIN:	State of Incorporation:
	Name of Corporate Officer:		DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Title of Corporate Officer:			Social Security #:
	Home Address:			Phone #:
	City:		State:	ZIP:
2.	Name of Corporate Officer:		DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Title of Corporate Officer:			Social Security #:
	Home Address:			Phone #:
	City:		State:	ZIP:
3.	Name of Corporate Officer:		DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Title of Corporate Officer:			Social Security #:
	Home Address:			Phone #:
	City:		State:	ZIP:

**If A Sole Proprietorship:**

1.	Individual's Full Legal Name:			<input type="checkbox"/> Male <input type="checkbox"/> Female
	DOB:	Social Security #:	Drivers License # and State:	
	Home Address:		Phone #:	FEIN:
	City:		State:	ZIP:
	DBA:		Division of Corporations DBA Registration #:	

**If A Limited Liability Company (LLC):** (Use additional sheets if necessary)

Name of the LLC:		FEIN:	State of Organization:		
1.	Name of Member:		Social Security #:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Home Address:			Phone #:	
	City:		State:	ZIP:	
	Name of Manager:		Social Security #:	DOB:	<input type="checkbox"/> Male <input type="checkbox"/> Female
	Home Address:			Phone #:	
	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 Owner/Officer/Individual being fingerprinted: \_\_\_\_\_

Date of Signature: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name of Owner/Officer/Individual being fingerprinted: \_\_\_\_\_

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Signature of Owner/Officer/Individual being fingerprinted: \_\_\_\_\_

Date of Signature: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name of Owner/Officer/individual being fingerprinted: \_\_\_\_\_

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Signature of Owner/Officer/Individual being fingerprinted: \_\_\_\_\_

Date of Signature: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name of Owner/Officer/Individual being fingerprinted: \_\_\_\_\_

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Signature of Owner/Officer/Individual being fingerprinted: \_\_\_\_\_

Date of Signature: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name of Owner/Officer/Individual being fingerprinted: \_\_\_\_\_

## COMPLIANCE WITH UTAH LAWS AND RULES

**Please Note: All owners, officers, managers, pharmacists or pharmacy technicians submitting fingerprint with this application; associated with, or employed by the applicant must sign and date the Compliance with Utah Laws and Rule.**

As an owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant, I understand that it is my 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: \_\_\_\_\_

## 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. Has any owner, officer, manager, pharmacist, pharmacy intern, or pharmacy technician associated with or employed by the applicant 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, pharmacy intern, 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, pharmacy intern, 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, pharmacy intern, 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, pharmacy intern, 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, pharmacy intern, 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, pharmacy intern, 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, pharmacy intern, 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, pharmacy intern, 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, pharmacy intern, 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 action been taken, or is any action pending against any owner, officer, manager, pharmacist, pharmacy intern, or pharmacy technician associated with or employed by the applicant by a third party payor?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Has any owner, officer, manager, pharmacist, pharmacy intern or pharmacy technician associated with or employed by the applicant currently or previously been associated in business with any person, partnership, corporation, or other entity, shared a financial or community property interest with any person or entity who has had any type of criminal, civil or administrative legal action taken against them by any governmental agency?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Has any owner, officer, manager, pharmacist, pharmacy intern 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	14. Has any owner, officer, manager, pharmacist, pharmacy intern, 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	15. Is any action now pending against any owner, officer, manager, pharmacist, pharmacy intern, 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	16. Has any owner, officer, manager, pharmacist, pharmacy intern, 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	17. Has any owner, officer, manager, pharmacist, pharmacy intern, 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	18. Has any owner, officer, manager, pharmacist, pharmacy intern, 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	19. If an owner, officer, manager, pharmacist, pharmacy intern, or pharmacy technician associated with or employed by the applicant is licensed in the occupation/profession for which the applicant is applying, would any owner, officer, manager, pharmacist, pharmacy intern, 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	20. Has any owner, officer, manager, pharmacist, pharmacy intern, 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	21. Has any owner, officer, manager, pharmacist, pharmacy intern, 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	22. Is any owner, officer, manager, pharmacist, pharmacy intern, 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	23. Has any owner, officer, manager, pharmacist, pharmacy intern, 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	24. Has any owner, officer, manager, pharmacist, pharmacy intern, 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	25. Has any owner, officer, manager, pharmacist, pharmacy intern, or pharmacy technician associated with or employed by the applicant have any criminal action pending?
<input type="checkbox"/> Yes <input type="checkbox"/> No	26. Has any owner, officer, manager, pharmacist, pharmacy intern, or pharmacy technician associated with or employed by the applicant ever pled guilty to, no contest to, or been convicted of a felony in any jurisdiction?
<input type="checkbox"/> Yes <input type="checkbox"/> No	27. Has any owner, officer, manager, pharmacist, pharmacy intern, or pharmacy technician associated with or employed by the applicant 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	28. Has any owner, officer, manager, pharmacist, pharmacy intern or pharmacy technician associated with or employed by the applicant 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	29. Has any owner, officer, manager, pharmacist, pharmacy intern, or pharmacy technician associated with or employed by the applicant, 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><b>If any owner, officer, manager, pharmacist, pharmacy intern, or pharmacy technician associated with or employed by the applicant answered “yes” to questions 23, 24, 25, 26, or 27 above, the owner, officer, manager, pharmacist, pharmacy intern, or pharmacy technician associated must submit a complete narrative of the circumstances that occurred for EACH and EVERY conviction, plea in abeyance, and/or deferred sentence. Any owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant must also attach copies of all applicable police report(s), court record(s), and probation/parole officer report(s).</b></p> <p>If any owner, officer, manager, pharmacist, pharmacy intern, or pharmacy technician associated with or employed by the applicant are unable to obtain any of the records required above, the owner, officer, manager, pharmacist, or pharmacy technician associated with or employed by the applicant must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.</p> <p>If any owner, officer, manager, pharmacist, pharmacy intern, or pharmacy technician associated with or employed by the applicant have formally expunged a criminal record as evidenced by a court order signed by a judge, any owner, officer, manager, pharmacist, pharmacy intern, or pharmacy technician associated with or employed by the applicant does 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><b>If any owner, officer, manager, pharmacist, pharmacy intern, or pharmacy technician associated with or employed by the applicant 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.</b></p> <p><b>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.</b></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		Social Security #:	
PIC Telephone #:	E-mail:	Facility Tax ID (FEIN/ITIN):	
State of Licensure:	Pharmacist License #:	Controlled Substance License #:	

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

Name of Consulting Pharmacist		Social Security #:	
Telephone #:		Facility Tax ID (FEIN/ITIN):	
Pharmacist License #:	Controlled Substance License #:	E-Mail:	
Physical Address of the Branch Pharmacy:			
City:		State:	ZIP:
Telephone #:		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:	E-Mail:
Pharmacy License #:	Controlled Substance License #:		
Name of Pharmacist-In-Charge		E-Mail:	
City:	State:	ZIP:	
Pharmacist License #:	Controlled Substance License #:		

**PARENT PHARMACY SUPERVISING PHARMACIST WILLING TO ASSUME RESPONSIBILITY AS CONSULTING PHARMACIST FOR THE BRANCH PHARMACY:**

Name :	E-Mail:
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, <b>is included with this application.</b>
<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, <b>is included with this application</b>
<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, <b>is included with this application.</b>
<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, <b>is included with this application.</b>

<b>CLASS B: CLOSED DOOR</b>		
Name of Pharmacist-In-Charge		Social Security #:
Telephone #:		Facility Tax ID (FEIN/ITIN):
Pharmacist License #:	Controlled Substance License #:	E-Mail:

<b>CLASS B: METHADONE CLINIC OR PHARMACEUTICAL ADMINISTRATION FACILITY</b>		
Name of Consulting Pharmacist		Social Security #:
Consulting Pharmacist Telephone #:		Facility Tax ID (FEIN/ITIN):
Pharmacist License #:	Controlled Substance License #:	E-Mail:

<b>CLASS B: NUCLEAR PHARMACY</b>		
Name of Pharmacist-In-Charge		Social Security #:
PIC Telephone #:		Facility Tax ID (FEIN/ITIN):
Utah Pharmacist License #:	Controlled Substance License #:	
Utah Radioactive Materials License #:	E-Mail:	

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

**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 #:

Tax ID (FEIN/ITIN):

Category or Classification of License:

Name of Pharmacist in Charge:

License # and State:

Date of Last Inspection by Licensing Authority:

Patient Toll Free Contact Telephone Number:

Availability for Patient Counseling:

Days:

Hours:

 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: All Class E applicants are required to submit the following in accordance with the Pharmacy Practice Act Rule, R156-17b-617a Operating Standards – General Provisions:**

(1) In accordance with Section 58-17b-302 and Subsection 58-17b-601(1), Class E pharmacies shall have a written pharmacy care protocol which includes: (a) the identity of the supervisor or director; (b) a detailed plan of care; (c) the identity of the drugs that will be purchased, stored, used and accounted for; and (d) the identity of any licensed healthcare provider associated with the operation.

**CLASS E: ANALYTICAL LABORATORY**

Laboratory Director Name:

Address:

E-Mail:

City:

State:

ZIP:

Telephone Number:

Tax ID (FEIN/ITIN):

**PROTOCOL:** In accordance with R156-17b-617a and R156-17b-617b, the Analytical Laboratory must provide the identity of the supervisor or director; a detailed plan of care; describe how prescription drugs will be purchased, stored, used, and accounted for; measures to prevent the loss or theft of controlled substances and provide the identify of any licensed health care provider associated with the pharmacy. *(Use additional sheets if necessary.)*

**CLASS E: ANIMAL EUTHANASIA**

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

PROTOCOL: In accordance with the Pharmacy Practice Act Rule, R156-17b-617a and R156-17b-617c, describe how prescription drugs will be purchased, stored, used, and accounted for; measures to prevent the loss or theft of controlled substances; and the training and supervision of employees. *(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. The Pharmacy Practice Act Rule, R156-17b-102 reads: (17) "Durable medical equipment" or "DME" means equipment that (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) generally is not useful to a person in the absence of an illness or injury; (d) is suitable for use in a health care facility or in the home. (26) "Medical supplies" means items for medical use that are suitable for use in a health care facility or in the home and that are disposable or semi-disposable and are non-reusable.

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

Include the following documents with the application:

<input type="checkbox"/> Yes <input type="checkbox"/> No	A 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 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.

PROTOCOL: In accordance with the in the Pharmacy Practice Act Rule, section R156-17-617d, please describe where durable medical equipment will be stored, used, and accounted for. *(Use additional sheets if necessary.)*

**CLASS E: HUMAN CLINICAL INVESTIGATIONAL DRUG RESEARCH FACILITY:**

Contact Person:

Social Security #:

Facility Name:

Address:

City:

State:

ZIP:

Telephone Number:

E-Mail:

Tax ID (FEIN/ITIN):

PROTOCOL: In accordance with the Pharmacy Practice Act Rule, R156-17b-617e, please describe how prescription drugs will be purchased, stored, used and accounted for; measures to prevent the loss or theft of controlled substances; and the training and supervision of employees. Please note that R156-17b-617e(4) requires a separate license for each principal place of business or professional practice where the applicant manufactures, produces, distributes, dispenses, conducts research with, or perform laboratory analysis upon controlled substances. *(Use additional sheets if necessary.)*

**CLASS E: MEDICAL GAS PROVIDER:**

Contact Person:

Social Security #:

Facility Name:

Address:

City:

State:

ZIP:

Telephone Number:

E-Mail:

Tax ID (FEIN/ITIN):

A Class E Medical Gas Provider must follow the operating standards listed in the Pharmacy Practice Act Rule, R156-17b-617f. List past experience in the working with the storage and handling of medical gases. *(Use additional sheets if necessary.)*

## 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:	
Pharmacy Name:			
Pharmacy Address:		E-Mail:	
Telephone:		Fax:	
Type of Pharmacy: <b>CLASS A:</b> <input type="checkbox"/> Retail  <b>CLASS B:</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		<b>CLASS D:</b> <input type="checkbox"/> Out-of-State Mail Order  <b>CLASS E:</b> <input type="checkbox"/> Central Order Entry Processing	
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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**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 #:		Expiration Date:	
DOPL Controlled Substance License #:		Expiration Date:	
DEA Registration #:		Expiration Date:	
List ALL Pharmacists, Interns and Pharmacy Technicians. <i>(Attach a separate sheet, if necessary.)</i>			
Pharmacist-in-Charge:	License Number:	Expiration Date:	
Pharmacist-in-Charge E-Mail:			
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:	
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. <a href="#">Pharmacy Practice Act Rule, R156-17b-601</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-603</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-304</a>
<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. <a href="#">Pharmacy Practice Act, 58-17b-603</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-603</a>
<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. <a href="#">Pharmacy Practice Act, 58-17b-603</a>
<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. <a href="#">Pharmacy Practice Act, 58-17b-613</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-610</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a>
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	10. The facility shall be well lighted, ventilated, clean and sanitary. <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a>
<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: <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a> <ul style="list-style-type: none"> <li>• <a href="#">DOPL Licensing Act, 58-1</a></li> <li>• <a href="#">Pharmacy Practice Act, 58-17b</a></li> <li>• <a href="#">General Rule for DOPL, R156-1</a></li> <li>• <a href="#">Pharmacy Practice Act Rule, R156-17b</a></li> </ul>

	<ul style="list-style-type: none"> <li>• <a href="#">Utah Controlled Substances Act, 58-37</a></li> <li>• <a href="#">Code of Federal Regulations – CRF Title 21</a></li> <li>• General Drug References</li> <li>• <a href="#">Utah Controlled Substance Act Rule, R156-37</a></li> <li>• <a href="#">FDA – Orange Book: Approved Drug Products</a></li> </ul>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-614a</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-612</a>
<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. <a href="#">Pharmacy Practice Act Rule, R156-17b-605</a>
<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. <a href="#">16 CFR 1700 – Poison Prevention Packaging</a>
<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: <a href="#">Pharmacy Practice Act, 58-17b-602</a> <ul style="list-style-type: none"> <li>• Name, Address, &amp; Phone Number of Pharmacy</li> <li>• Filling Date or Last Dispensing Date</li> <li>• Name of the Prescriber</li> <li>• Trade, Generic or Chemical Name</li> <li>• Serial Number of Prescription</li> <li>• Name of the Patient or Animal Owner / Species</li> <li>• Directions For Use &amp; Cautionary Statements</li> <li>• Amount Dispensed &amp; Strength of Dosage Form</li> <li>• Beyond Use Date</li> </ul> <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. <a href="#">Utah Controlled Substance Act Rule, R156-37-602</a>
<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. <a href="#">Utah Controlled Substance Act Rule, R156-37-602</a>
<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. <a href="#">21 CFR 1311 – Requirement for Electronic Orders and Prescriptions</a>
<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. <a href="#">Controlled Substance Database Act, 58-37f-203</a>
<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. <a href="#">Utah Controlled Substance Act Rule, R156-37-609</a>
<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. <a href="#">Utah Controlled Substance Act Rule, R156-37-602</a>
<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. <a href="#">Online Prescribing, Dispensing, and Facilitation Licensing Act, 58-83-501 and 503</a>
<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. <a href="#">Pharmacy Practice Act, 58-17b-602</a>
<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. <a href="#">Pharmacy Practice Act, 58-17b-503 and 502</a>
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:	
Printed Name of Pharmacist-in-Charge:	Date of Signature:

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

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

PHARMACY LICENSE NUMBER: \_\_\_\_\_

CONTROLLED SUBSTANCE LICENSE NUMBER: \_\_\_\_\_

TO ACT AS A \_\_\_\_\_  
*(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     OTHER (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: \_\_\_\_\_

TITLE: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

**DO NOT WRITE IN THIS SECTION – FOR DIVISION USE ONLY**

ACCEPTED BY THE DIVISION: \_\_\_\_\_

TITLE: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

THE SURRENDER OF THIS LICENSE WILL BE SIMULTANEOUS WITH SUCCESSFUL COMPLETION OF THE INSPECTION.