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

Temporary Pharmacy- Class D Out of State Mail Order

For Declared Emergency Only

APPLICANT INFORMATION

Business Legal Name _____

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

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

Address: _____

Street Address (including Apt/Unit/Ste #)

_____

City *State* *ZIP Code*

Phone: _____ **Email:** _____

Contact for Licensing Purposes: _____

Phone: _____ **Email:** _____

AFFIDAVIT AND RELEASE

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

Signature of Authorized Signer: _____ Date: _____

Printed Name of the Authorized Signer: _____

Position of Authorized Signer: _____

QUALIFYING QUESTIONNAIRE

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

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

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

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

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

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

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

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

CLASS D SUBTYPE

Please select all the subtypes that apply:

- ☐ Sterile Compounding
- ☐ Non Sterile Compounding
- ☐ Hazardous Compounding

PHARMACIST IN CHARGE

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

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

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

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

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

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

Signature of PIC: _____ Date: _____

PHARMACIST IN CHARGE SUPERVISOR

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

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

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

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

Signature of Supervisor: _____ Date: _____

UTAH CONTROLLED SUBSTANCE AFFIDAVIT (OPTIONAL)

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

1. I have reviewed and understand that I must abide by the additional laws and rules that govern the practice of my profession as it pertains to controlled substances.
2. I understand it is required that I hold a valid Federal Drug Enforcement Administration (DEA) registration.

Signature of Applicant: _____ Date _____

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

PHARMACY INFORMATION

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

State of Licensure: _____ **State License Number:** _____

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

Patient Toll Free Contact Telephone Number: _____

Days and hours of availability for patient counseling: _____

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

MEDICAL QUALIFYING QUESTIONNAIRE

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

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

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

- ☐ Yes ☐ No a hospital or health care facility
- ☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- ☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
- ☐ Yes ☐ No malpractice insurance coverage
- ☐ Yes ☐ No other entity: _____

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

- ☐ Yes ☐ No a hospital or health care facility
- ☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- ☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
- ☐ Yes ☐ No malpractice insurance coverage
- ☐ Yes ☐ No other entity: _____

3. Is any action pending against you now by:

- ☐ Yes ☐ No a hospital or health care facility
- ☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
- ☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
- ☐ Yes ☐ No malpractice insurance coverage
- ☐ Yes ☐ No other entity: _____

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

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

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

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

CLASS D CONTROLLED SUBSTANCE DATABASE QUESTIONNAIRE

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

PIC: _____ **Email:** _____

Pharmacy Name: _____ **Email:** _____

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

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

Contact Name of Person who will set up CSD Transmittal: _____

Phone Number: _____ Email: _____

CSD Transmittal Software Vendor: _____

POS Software Vendor (if different): _____

NCPDP/NABP Number *(required)*: _____

NPI Number: _____ DEA Number: _____

Anticipated Date of Beginning Operations: _____

1. ☐ Yes ☐ No	I am the pharmacist-in-charge of the above named facility.
2. ☐ Yes ☐ No	I understand that I must ensure that prior to dispensing any controlled substances, the proper arrangements have been made to report to the database.
3. ☐ Yes ☐ No	I will submit all required data regarding every prescription for a controlled substance dispensed in Utah by me and all pharmacists under my supervision to any person other than an inpatient in a licensed health care facility in accordance with the Section 58-37f-203.
4. ☐ Yes ☐ No	I have read and understand Section 58-37f-203 of the Utah Controlled Substances Act.

Signature of PIC: _____ **Date:** _____

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

APPLICATION CHECKLIST AND INSTRUCTION

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

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

"Class D pharmacy" means a nonresident pharmacy.

ALL APPLICANTS

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

- ☐ Official Verification or Primary Source Verification from the Board of Pharmacy of the state where the pharmacy is physically located indicating licensure in good standing.
- ☐ Copy of the most recent state inspection report or NABP inspection where the pharmacy is physically located indicating compliance with laws and regulations for the facility. If engaging in Compounding, it must be conducted within two years before application of licensure.
- ☐ Provide a statement of the scope of pharmacy services that will be provided and a detailed description of the protocol as described by rule by which pharmacy care will be provided, including any collaborative practice arrangements with other health care practitioners in accordance with Utah Code 58-17b-306(2)(d).
- ☐ Copy of a current license for the Pharmacist-in-Charge

OPTIONAL TEMPORARY CONTROLLED SUBSTANCE LICENSE

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

- ☐ Complete the "Utah Controlled Substance Law and Rule Affidavit" found on page 4 of this application.
- ☐ Completed "Utah Controlled Substance Database Questionnaire" found on page 6 of this application

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

Submit the above items with your completed application to:

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

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