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

Pharmacy- Dispensing Medical Practitioner Clinic Pharmacy

APPLICANT INFORMATION

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

DBA ***(if applicable):*** ______________________________

Address: ______________________________
Street Address (including Apt/Unit/Ste #)

____
City *State* *ZIP Code*

Phone: ____________________ **Email:** ____________________

Contact for Licensing Purposes: ______________________________

Phone: ____________________ **Email:** ____________________

AFFIDAVIT AND RELEASE

1. I certify that I am qualified in all respects for the license for which I am applying in this application.

2. I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.

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

4. I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

5. I certify that I do not currently pose a direct threat to myself, to my clients, or to the public health, safety or welfare because of any circumstance or condition.

6. I understand that I am responsible to update the Division of any changes relating to my license/certification/registration.

Signature of Authorized Signer: ______________________________ Date: __________

Printed Name of the Authorized Signer: ______________________________

Position of Authorized Signer: ______________________________

BUSINESS ORGANIZATION

Please select entity type:

- ☐ Business Trust
- ☐ Corporation
- ☐ General Partnership
- ☐ Limited Liability Company
- ☐ Limited Partnership
- ☐ Limited Liability Partnership

If registered as one of the above entities, complete only Section 1 below.

- ☐ Sole Proprietorship

If registered as sole proprietorship, complete only Section 2 below.

Section 1: To be completed by Corporation, LLC, LP and LLP applicants only.

UT Division of Corporation Registration Number: ____________________ Tax Id Number: ________________

Select one: ☐ Domestic ☐ Foreign   Is this company publicly traded? ☐ Yes ☐ No

DBA (if applicable) : ____ DBA Registration Number: ________________

It is required that all entities doing business in Utah register with the Division of Corporation and Commercial Code.* ***You may reach the Utah Division of Corporations and Commercial Code at www.corporations.utah.gov or 1-877-526-3994.*

I understand that in all areas of this application the words “you”, “I” and “applicant” apply to the entity listed above and all subsidiaries, owners, officers, managers, qualifiers and prior entities for which these individuals have been involved.

Signature of Authorized Signer: ____ Date: ____________

Printed Name of the Authorized Signer: ____

Position of Authorized Signer: ____

Section 2: To be completed by Sole Proprietorship applicants only.

Full Legal Name: ____

First *Middle* *Last*

All Previous Legal Names: ____

Other DOPL Licenses Held: ____

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

Please Select ONE:

- ☐ I am a United States citizen OR a non-citizen of the United States who is lawfully present.
- ☐ I am a foreign national not physically present in the United States.
- ☐ None of the above, please explain: ____

Driver License or State ID Card ____

State of Issue *License Number* *Expiration Date*

NOTE: If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of authorization to work in the United States.

If applicable, please complete the following:

UT Division of Corporation Registration Number: ____________________ Tax Id Number: ________________

DBA: ____ DBA Registration Number: ________________

RESPONSIBLE DISPENSING MEDICAL PRACTITIONER (RDMP)

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

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

License Number ____________________ **State of Issue:** ____________________

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

Signature of RDMP: ______________________________ Date ____________________

DISPENSING SUBTYPE

Please select the type of drug to be dispensed (check all that apply).

☐ Cosmetic Drugs

☐ Cancer Drug Treatment Regimen

☐ Injectable Weight Loss Drugs

☐ Prepackaged Drugs (*Employer Sponsored Clinic)*

☐ Legend, non-controlled drugs approved under Section R156- 83-306 for prescribing by an online prescriber

CLASS A CONTROLLED SUBSTANCE DATABASE QUESTIONNAIRE

To be completed by the dispensing medical practitioner of all facilities dispensing cancer drug treatment regimens that will include controlled substances

Clinic Name: ______________________ **Email:** ______________________

Clinic Address: ____
Street Address (including Apt/Unit/Ste #) *City* *State* *ZIP*

Clinic Telephone: ______________________ **Clinic 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 dispensing medical practitioner 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 DMPIC: ______________________ **Date** ______________________

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For Official Use Only

Applicant Number(s): ______________________ Conditional Expiration: ______________________

Licensing Specialist: ______________________ Date of Referral: ______________________

Reason for Application: ______________________ Subtype (*if applicable):* ______________________

Notes:

DISPENSING MEDICAL CLINIC INSPECTION REFERRAL

Clinic Name: ______________________________ **Email:** ______________________________

Clinic Address: ____

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

Clinic Telephone: ______________________________ **Clinic Fax:** ______________________

RDMP: ______________________________ **RDMP Telephone:** ______________________

RDMP License # ______________________________ **RDMP Email:** ______________________

Local Contact Person: ____

Local Contact Telephone: ____________________ **Local Contact Email:** ____________________

Clinic Hours of Operation: ____

I understand that all entities licensed under Sections 58-17b-301 and 58-17b-302 shall comply with all state and federal laws and regulations relating to the practice of pharmacy, and that by making this application for licensure, attest to full compliance with said laws.

I acknowledge that whenever an applicable statute or rule requires or prohibits action by a pharmacy, the dispensing medical practitioner and the owner of the pharmacy shall be responsible for all activities of the pharmacy, regardless of the form of the business organization.

I understand that a conditional pharmacy license may be issued to this pharmacy pending inspection and verification of compliance with the operating standards that apply to the practice of pharmacy. The outcome of the inspection is necessary to determine whether all licensure requirements are met, and a conditional pharmacy license is not renewable. I acknowledge the division's authority to inspect the licensee's business premises pursuant to Section 58-17b-103.

I attest that the information contained in this application is truthful, correct and complete. I understand that it is unlawful and punishable as a Class A Misdemeanor to deal with DOPL or the Licensing Board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

Signature of RDMP: ____ **Date:** ____________________

For Official Use Only

License Number(s): ______________________ Conditional Expiration: ______________________

Licensing Specialist: ______________________ Date of Referral: ______________________

Reason for Application: ______________________ Subtype (*if applicable):* ______________________

Notes:

APPLICATION CHECKLIST AND INSTRUCTIONS

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

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

ALL APPLICANTS

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

- ☐ $200.00 non-refundable application-processing fee, made payable to "DOPL".
- ☐ Completed "Dispensing Medical Clinic Inspection Referral" on page 4 of this application.

CANCER DRUG TREATMENT REGIMEN APPLICANTS

- ☐ Submit documentation of the RDMP's medical oncology certification or eligibility.

Submit the above items with your completed application to:

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

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

If you have questions, feel free to contact the Division via our direct email address, doplbureau3@utah.gov , or via the phone or fax listed below.