

## Pharmacy: Class D – Out of State Mail Order

### APPLICANT INFORMATION

Business Legal Name: \_\_\_\_\_

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

Utah Division of Corporation  
Registration Number: \_\_\_\_\_

IRS Employee ID  
Number (EIN): \_\_\_\_\_

DBA (if applicable): \_\_\_\_\_

DBA Registration  
Number: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_  
*Street Address (including Apt/Unit/Ste #) and/or PO Box*

\_\_\_\_\_

City

State

ZIP Code

**You will receive all Division notices and communications at the following email.**

Email: \_\_\_\_\_  
*Email Address is Required.*

Company Phone: \_\_\_\_\_

Local Contact for Licensing Purposes: \_\_\_\_\_

Alternate Phone for Local Contact: \_\_\_\_\_

Direct Email of Contact Person: \_\_\_\_\_

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, qualifiers, and prior entities and DBA’s for which these individuals have been involved.

### 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 and Position of the Authorized Signer: \_\_\_\_\_

**GENERAL BUSINESS INFORMATION**

**Section 1: Please select entity type:**

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

- Sole Proprietorship  
*If registered as sole proprietorship, complete Section 2 below.*

**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's License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.

**PROFESSIONAL LICENSES**

List all other licenses, registrations or certifications issued by any state which you now hold or have ever held in any profession. *(Use additional sheets if necessary.)*

Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Profession: \_\_\_\_\_ License Number: \_\_\_\_\_

Issuing State: \_\_\_\_\_ License Status: \_\_\_\_\_ Issue Date: \_\_\_\_\_

**REASON FOR APPLICATION**

*Select all that apply*

**\*Note that a Surrender Form is required for Change of Name, Change of Location, or Change of Ownership**

New Facility \_\_\_\_\_

Utah License Number: \_\_\_\_\_

Change of Name Current Name: \_\_\_\_\_

Effective Date of Change \_\_\_\_\_

Change of Location Utah License Number: \_\_\_\_\_

Current Address \_\_\_\_\_

Proposed Date of Change: \_\_\_\_\_

Change of Ownership of Existing Pharmacy Utah License Number: \_\_\_\_\_

Effective Date of Change: \_\_\_\_\_

## QUALIFYING QUESTIONNAIRE

### Do not leave any question blank.

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, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?
2.  Yes  No Do you CURRENTLY have **any criminal action active or pending**?
3.  Yes  No WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted of a misdemeanor** in any jurisdiction?
4.  Yes  No Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted of a felony** in any jurisdiction?

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 2, 3, or 4 you must submit the following for EACH and EVERY incident:

- personal account of the incident
- court record(s)
- police report(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.

#### NOTE:

- **DISCLOSE** charges that were later held in abeyance, diverted, reduced, or dismissed.
- **DISCLOSE** motor vehicle offenses such as driving while impaired or intoxicated. But you do not need to disclose minor traffic offenses such as parking or speeding violations.
- You do not need to report Juvenile Court adjudications; however, you do need to report convictions as a minor tried outside of Juvenile Court.
- **DISCLOSE** if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).
- You do **not need to disclose** legally expunged or sealed criminal history incidents.

For more information, see [DOPL's criminal history FAQs](#).

## CLASS D SUBTYPE

**Please select all the subtypes that apply:**

- Sterile Compounding  Hazardous Compounding  
 Non Sterile Compounding  No Compounding will be performed

## UTAH CONTROLLED SUBSTANCE AFFIDAVIT (OPTIONAL)

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

1. I have reviewed and understand that I must abide by the additional laws and rules that govern the practice of my profession as it pertains to controlled substances.
2. I understand that there may be additional continuing education requirements for those who hold a controlled substance license.
3. I understand it is required that I hold a valid Federal Drug Enforcement Administration (DEA) registration.

Signature of Applicant: \_\_\_\_\_ Date \_\_\_\_\_

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

## 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.

## 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.

## PHARMACIST IN CHARGE

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

**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

By signing below, 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.

### Criminal History Disclosure

Fingerprints submitted with this application are used to complete a search through the files of the Utah Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigations (FBI). Prior to submitting fingerprints, you must read and acknowledge, by signing the affidavit below, the Privacy Act Statement found at:

<https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement>. Physical copies of this statement may also be obtained upon request from the Division.

The criminal record information obtained by this search will be used by Division staff to evaluate your ability to obtain licensure in Utah. You may challenge or review your criminal record. For additional information regarding the challenge or review process, please see below.

By signing below, you acknowledge receipt of this information and consent to the background check process described above.

Signature of PIC: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_  
*Street/PO Box City State/Zip*

**Please see our website, [www.dopl.utah.gov/fingerprints.html](http://www.dopl.utah.gov/fingerprints.html), for required information and approved locations to obtain fingerprints.**

**REVIEW OF YOUR CRIMINAL RECORD:** If you wish to review or 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. Please see their website at: <https://www.fbi.gov/services/cjis/identity-history-summary-checks>. You may also contact them via mail at: FBI: CJIS Division, Attn. Criminal History Analysis Team 1, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will forward the challenge to the respective agency.

If you wish to review or challenge the accuracy of the information in your BCI record, you must complete the required "Record Challenge Form", available at: <https://bci.utah.gov/criminal-records/criminal-records-forms/>, and submit it directly to BCI.

Agency review of a licensing decision based on your criminal record may be obtained by filing a written request for agency review with the Executive Director of the Department of Commerce within thirty (30) days after notification of the decision. Any such request must comply with the requirements of Utah Code § 63G-4-301 and Utah Admin. Code R151-4-902.

## 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 information below and the checklist at the end of this application for additional information.

**Full Legal Name:** \_\_\_\_\_  
*First Middle Last*

**SSN:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Gender:**  Male  Female

By signing below, 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.

### Criminal History Disclosure

Fingerprints submitted with this application are used to complete a search through the files of the Utah Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigations (FBI). Prior to submitting fingerprints, you must read and acknowledge, by signing the affidavit below, the Privacy Act Statement found at: <https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement>. Physical copies of this statement may also be obtained upon request from the Division.

The criminal record information obtained by this search will be used by Division staff to evaluate your ability to obtain licensure in Utah. You may challenge or review your criminal record. For additional information regarding the challenge or review process, please see below.

By signing below, you acknowledge receipt of this information and consent to the background check process described above.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_  
*Street/PO Box City State/Zip*

**Please see our website, [www.dopl.utah.gov/fingerprints.html](http://www.dopl.utah.gov/fingerprints.html), for required information and approved locations to obtain fingerprints.**

**REVIEW OF YOUR CRIMINAL RECORD:** If you wish to review or 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. Please see their website at: <https://www.fbi.gov/services/cjis/identity-history-summary-checks>. You may also contact them via mail at: FBI: CJIS Division, Attn. Criminal History Analysis Team 1, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will forward the challenge to the respective agency.

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Agency review of a licensing decision based on your criminal record may be obtained by filing a written request for agency review with the Executive Director of the Department of Commerce within thirty (30) days after notification of the decision. Any such request must comply with the requirements of Utah Code § 63G-4-301 and Utah Admin. Code R151-4-902.

## CLASS D PHARMACY 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.



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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: \_\_\_\_\_ PHARMACY WITHIN THE STATE OF UTAH.  
*(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    N/A (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: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_



## 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".
- \$60.00 non-refundable Fingerprint Processing fee (\$30 each) for the PIC and the PIC's Direct Supervisor.
  - **Please Note:** If the PIC is the Sole Owner, and has no direct supervisor, please include a copy of the company's organizational chart and only \$30.00.
- Fingerprints to be used by DOPL for a fingerprint search through the files of the Utah Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigations (FBI). Please see our website, [www.dopl.utah.gov/fingerprints.html](http://www.dopl.utah.gov/fingerprints.html), for required information and approved locations to obtain fingerprints
- Official 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
- Surrender Form due to Change of Name, Change of Location, or Change of Ownership.

### OPTIONAL CONTROLLED SUBSTANCE LICENSE

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

- \$100.00 non-refundable application-processing fee, made payable to "DOPL".
- Complete the "Utah Controlled Substance Law and Rule Affidavit"
- Completed "Utah Controlled Substance Database Questionnaire"

**\*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, 1<sup>st</sup> 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, please contact the Division via our direct email address, [b3@utah.gov](mailto:b3@utah.gov), or via the phone or fax number listed below. Do not send applications to this email.