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

Official Use Only
Number: _____
Date Approved/Denied: _____
Approved/Denied By: _____

Online Internet Facilitator

APPLICANT INFORMATION

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

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

Mailing Address: _____
Street Address (including Apt/Unit/Ste #) and/or PO Box

_____
City *State* *ZIP Code*

Phone: _____ **Email:** _____

Local 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 in Utah, complete Section 1 below.

☐ Sole Proprietorship

If registered as sole proprietorship, complete Section 2 below.

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

UT Division of Corporation Registration Number*: _____ EIN: _____

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

DBA (if applicable) : _____ DBA Registration Number: _____

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.

**It is required that all entities doing business in Utah register with the Division of Corporation and Commercial Code.*

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: _____

Drivers 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 authorization to work in the United States.

If applicable, please complete the following:

UT Division of Corporation Registration Number: _____ SSN or EIN: _____

DBA: _____ DBA Registration Number: _____

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.

PROFESSIONAL LICENSES

List all other licenses, registrations or certification 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:** _____

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.

CONTRACTUAL SERVICES

Please list the Online Prescriber and Online Contract Pharmacy you have contracted with. If the license has not yet been issued, please write "Pending" and include the date the application was submitted. *If contracting with more than one online prescriber, please use additional sheets.*

Online Prescriber: _____ **License Number:** _____

Phone Number: _____

Contract Pharmacy: _____ **License Number:** _____

Contact Person: _____ **Phone Number:** _____

APPLICATION CHECKLIST AND INSTRUCTIONS

(This checklist is for your convenience, you do not need to include it with your application.)

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.

Submit the above items with your completed application to:
The following items are required to complete your application:

- $7,000 non-refundable application processing fee, made payable to "DOPL".
- Supporting documentation for any "yes" answers provided on either of the qualifying questionnaires. See pages 3 and 4 of the application for more information.
- Copies of the contracts between this facility, each online prescriber and the online contract pharmacy.
- Copies of the policies and procedures which address the requirements of 58-83-302 (4)(d)
- Copies of the policies and procedures which address patient confidentiality as required by 58-83-302(g)
- Documentation of your security measures to ensure the confidentiality and integrity of any user-identifiable medical information.
- documentation and description of the mechanisms for:
- Patients to access, supplement, and amend patient-provided personal health information
- Back-up regarding the Internet Facilitator electronic interface
- Quality of information and services provided via the interface
- Methods by which patients register complaints regarding the Internet Facilitator, the Online Prescriber, or the Online Contract Pharmacy
- Copy of the Internet Facilitator's website by including the URL, hard copy print of the main pages and, a site map showing all pages of the web site.

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