UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

Clear Form

Dispensing Medical Practitioner Clinic Pharmacy

APPLICANT INFORMATION

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

DBA *(if applicable)*: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ – _____ Email: _____
Note: All Division notices and communication will be sent to this email.

Local Contact for
Licensing Purposes: _____ _____
First *Middle* *Last*

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 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.

I declare under criminal penalty under the law of Utah that the foregoing is true and correct.

Authorized Signature: _____ Date: _____

Printed Name: _____ Title/Position: _____

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BUSINESS ORGANIZTION

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 Corporation, LLC, LP and LLP applicants only.

Corporations Registration Number*:_____Tax ID: _____

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

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.

Signature of Authorized Signer:_____Date: _____

Printed Name: _____Title/Position: _____

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 lawful presence in the United States.*

If applicable, please complete the following:

Corporations Registration Number:_____SSN or EIN:_____

DBA: _____DBA Registration Number: _____

DISPENSING MEDICAL PRACTITIONER IN-CHARGE (DMPIC)

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

Address: _____ City: _____ State: _____ Zip: _____

License Number: _____ Type: _____ State of Issue: _____

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

Address: _____ City: _____ State: _____ Zip: _____

I understand that as the **Dispensing Medical Practitioner In-Charge (DMPIC)**, licensed under Utah Code § 58-17b, as a Dispensing Medical Practitioner working with this Dispensing Medical Practitioner Clinic Pharmacy, I am designated by this dispensing medical practitioner clinic pharmacy to be responsible for *all* activities of the pharmacy.

I am familiar with my legal obligations under Utah Code § 58-17b-804 and Utah Administrative Code § R156-17b-603 and any others Rights, Responsibilities and Obligations enumerated under Utah or Federal Law. I understand that it is my responsibility to know the laws and rules governing this dispensing medical practitioner clinic pharmacy.

DMPIC Signature: _____ Date: _____

DISPENSING SUBTYPES

Please select the drug(s) approved under Utah Code § 58-17b-803 that will be dispensed (*attach a separate sheet if necessary*):

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

- ☐ Cosmetic Drugs
- ☐ Injectable Weight Loss Drugs
- ☐ Cancer Drug Treatment Regimen
- ☐ Prepackaged Drugs *(Employer Sponsored Clinic)*
- ☐ Hormonal Based Contraception *(except injectable or implantable methods);*
- ☐ Hydroquinone up to 4%;
- ☐ Tretinoin up to 0.1%;

CONTROLLED SUBSTANCE DATABASE QUESTIONNAIRE

Business Name: _____

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

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ – _____ Fax: (_____) _____ – _____

Email: _____

Note: All Division notices and communication will be sent to this email.

Person who will set up **Controlled Substance Database** transmittal: _____ _____ _____

First *Middle* *Last*

Phone: (_____) _____ – _____ Email: _____

CSD Transmittal Software Vendor: _____

POS Software Vendor (if different): _____

NCPDP Number (required): _____

NPI Number: _____ DEA Number: _____

Beginning Date of 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 Utah Code § 58-37f-203?
4.	☐ Yes ☐ No	I have read and understand Utah Code § 58-37f-203 of the Utah Controlled Substances Act?

I declare under criminal penalty under the law of Utah that this application is true and correct.

Signature of **DMPIC:** _____ Date: _____

For Official Use Only

Applicant Number(s): _____ Conditional Expiration: _____

Licensing Specialist: _____ Date of Referral: _____

Reason for Application: _____ Subtype (if applicable): _____

Notes:

UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

PHARMACY INSPECTION REFERRAL

Pharmacy Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ – _____ Fax: (_____) _____ – _____

Hours of Operation: _____

Please select the type(s) of compounding:

- ☐ No Compounding in Pharmacy
- ☐ Sterile Compounding
- ☐ Non Sterile Compounding
- ☐ Hazardous Compounding

Pharmacist in Charge (PIC):

Name: _____ _____ License Number: _____
First *Last*

Phone: (_____) _____ – _____ Email: _____

Local Pharmacy Contact:

Name: _____ _____ License Number: _____
First *Last*

Phone: (_____) _____ – _____ Email: _____

I acknowledge the Division's authority to inspect the licensee's business premises pursuant to Utah Code § 58-17b-103. I understand that all entities licensed under Utah Code § 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 pharmacist-in-charge 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 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 PIC: _____ Date: _____

For Official Use Only

License Number(s): _____ Expiration: _____

Licensing Specialist: _____ Date of Referral: _____

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 *each* **Dispensing Medical Practitioner**'s medical oncology certification or eligibility.

Return completed application to:

In person or via express delivery:
Division of Professional Licensing
Heber M Wells Building
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 or via the phone or fax listed below.