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

Pharmacy: Class B

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

☐ Change of Name
Utah License Number: _____
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
- 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.

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 B SUBTYPE

Please select the subtype that you are applying for:

- ☐ **Hospital:** A hospital pharmacy provides pharmaceutical care to inpatients of a general acute hospital or specialty hospital licensed by the Department of Health.
- ☐ **Branch Pharmacy:** A "branch pharmacy" means a pharmacy or other facility in a rural or medically underserved area used for the storage and dispensing of prescription drugs, which is dependent upon, stocked by and supervised by a pharmacist in another licensed pharmacy designated and approved by the division as the parent pharmacy.
- ☐ **Closed Door:** A "closed door pharmacy" means a pharmacy that provides pharmaceutical care to a defined and exclusive group of patients who have access to the services of the pharmacy because they are treated by or have an affiliation with a specific entity, including a health maintenance organization or an infusion company, but not including a hospital pharmacy, a retailer of goods to the general public, or the office of a practitioner.
- ☐ **Narcotic Treatment Program Pharmacy:** A "Narcotic Treatment Program Pharmacy" is a clinic which has been established for the dispensing of methadone, a schedule II opioid analgesic, to those who abuse heroin and other opioids.
- ☐ **Nuclear Pharmacy:** A "nuclear pharmacy" means a pharmacy providing radio-pharmaceutical service.
- ☐ **Pharmaceutical Administration Facility:** A "pharmaceutical administration facility" means a facility, agency, or institution in which:
  - (a) prescription drugs or devices are held, stored, or are otherwise under the control of the facility or agency for administration to patients of that facility or agency;
  - (b) prescription drugs are dispensed to the facility or agency by a licensed pharmacist or pharmacy intern with whom the facility has established a prescription drug supervising relationship under which the pharmacist or pharmacy intern provides counseling to the facility or agency staff as required, and oversees drug control, accounting, and destruction; and
  - (c) prescription drugs are professionally administered in accordance with the order of a practitioner by an employee or agent of the facility or agency.

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.

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.*

PHARMACIST IN CHARGE OR CONSULTING PHARMACIST

NOTE: In addition to completing this section, you must submit two completed fingerprint cards for the PIC/CP; 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:** _____

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/CP: _____

Printed Name: _____ Date: _____

Pharmacy Name: _____

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

Please see our website, 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 OR ON-SITE SUPERVISOR

NOTE: In addition to completing this section, you must submit two completed fingerprint cards for the PIC's immediate supervisor or the on-site 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, 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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CLASS B 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/CP: _____ **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/CP: _____ **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.*

CLASS B PHARMACY INSPECTION REFERRAL

Pharmacy Name: _____ **Email:** _____

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

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

PIC/CP: _____

PIC/CP License Number: _____ **PIC/CP Email:** _____

Local Contact Person: _____

Local Contact Telephone: _____ **Local Contact Email:** _____

Pharmacy Hours of Operation:

Parent Pharmacy *(Branch Pharmacies Only)*: _____

Parent Pharmacy License Number *(Branch Pharmacies Only)*: _____

Will you engage in compounding? ☐ Yes ☐ No If yes, please select the type(s) of compounding:

☐ Sterile Compounding ☐ Non Sterile Compounding ☐ Hazardous Compounding

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 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 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 PIC/CP: _____ **Date:** _____

For Official Use Only

License Number(s): _____ Conditional Expiration: _____

Licensing Specialist: _____ Date of Referral: _____

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

Notes:

BEFORE THE
DIVISION OF OCCUPATIONAL & PROFESSIONAL LICENSING
DEPARTMENT OF COMMERCE OF THE STATE OF UTAH

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 under 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.

Class B pharmacy is defined as a pharmacy located in Utah that is authorized to provide pharmaceutical care for patients in an institutional setting and whose primary purpose is to provide a physical environment for patients to obtain health care services and includes closed-door, hospital, clinic, nuclear, and branch pharmacies; and pharmaceutical administration and sterile product preparation facilities.

This pharmacy application should not be submitted to DOPL until the facility is substantially completed and is within six weeks of the anticipated date of opening.

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/CP and the PIC's Direct Supervisor or the On-Site Supervisor if no PIC is required by law.
    - **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, for required information and approved locations to obtain fingerprints.
- ☐ Completed "Pharmacy Inspection Referral" in this application.
- ☐ 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" found in this application.
- ☐ Completed "Controlled Substance Database Questionnaire" found in 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

If you have questions, please contact the Division via our direct email address, b3@utah.gov, or via the phone or fax listed below. **Do not** send applications to this email.