

Pharmacy: Class C
Pharmaceutical Wholesaler, Manufacturer, Distributor

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 C SUBTYPE

Please select all the subtypes that apply:

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Distributor | <input type="checkbox"/> Wholesaler |
| <input type="checkbox"/> Manufacturer | <input type="checkbox"/> Virtual |
| <input type="checkbox"/> Reverse Distributor | |

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.

DESIGNATED REPRESENTATIVE

NOTE: In addition to completing this section, you must submit two completed fingerprint cards for the DR; 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

List at least three years of experience in the manufacture or distribution of prescription drugs/devices

Employer Name: _____ Dates Employed: _____

Employer Name: _____ Dates Employed: _____

Employer Name: _____ Dates Employed: _____

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 DR: _____

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.

DESIGNATED REPRESENTATIVE SUPERVISOR

NOTE: In addition to completing this section, you must submit two completed fingerprint cards for the DR'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, 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 C PHARMACY INSPECTION REFERRAL

If the pharmacy is located in Utah, you must complete this form.

If the pharmacy is located outside of Utah, please submit a copy of your most current state or NABP inspection.

Pharmacy Name: _____ **Email:** _____

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

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

Designated Representative: _____

DR Phone Number _____ **DR Email:** _____

Local Contact Person *(if different than DR):* _____

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

Pharmacy Hours of Operation: _____

FDA Number (Manufacturers Only): _____

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 DR: _____ **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 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 C Pharmacy is defined as a pharmacy that is authorized to engage in the manufacture, production, wholesale, or distribution of drugs or devices. A separate license shall be obtained for each separate location.

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 Designated Representative (DR) and the DR's Direct Supervisor.
 - **Please Note:** If the DR 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.
- If the pharmacy is located in Utah, completed "Pharmacy Inspection Referral".
- If the pharmacy is located outside of Utah, submit a COPY of your most recent state or NABP inspection.

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"

***NOTE:** In addition to the Utah Controlled Substance License, you must hold a valid Federal Drug Enforcement Administration (DEA) registration.

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 number listed below. Do not send applications to this email.