UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

Licensed Dispensing Practice

Clear Form

APPLICANT INFORMATION

Clinic Name: _____

Contact Name: _____ _____ _____
First *Middle* *Last*

Address: _____

City: _____ State: _____ Zip: _____

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.

Signature of Affiant: _____ Date: _____

Printed Name: _____

UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

RESPONSIBLE DISPENSING PRACTITIONER (RDP)

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

Previous Legal Names: _____

Address: _____

Other licenses held in Utah: _____

License Type:

- ☐ Physician/Surgeon
- ☐ Osteopathic Physician/Surgeon
- ☐ Physician Assistant
- ☐ APRN

DOPL License Number: _____

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.

Signature of RDP: _____ Date: _____

APPLICATION CHECKLIST AND INSTRUCTIONS

***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.

The following items are required to complete your application:

- ☐ $110.00 non-refundable application-processing fee, made payable to "DOPL".
- ☐ Designation of a Responsible Dispensing Practitioner.

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 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.

UTAH DEPARTMENT OF COMMERCE
Division of Professional Licensing

INSPECTION REFERRAL

Clinic Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Clinic Hours of Operation: _____

Responsible Dispensing Practitioner:

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

Phone: (_____) _____ – _____ Email: _____

DOPL License Number: _____

I understand that all entities licensed under Utah Code § 58-88-202 shall comply with all state and federal laws and regulations relating to the practice 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 licensed dispensing practice, the responsible dispensing practitioner and the owner of the dispensing practice shall be responsible for all activities of the licensed dispensing practice, regardless of the form of the business organization.

I understand that a conditional dispensing practice license may be issued to this clinic pending inspection and verification of compliance with the operating standards that apply to the practice of a dispensing practice. The outcome of the inspection is necessary to determine whether all licensure requirements are met, and a conditional dispensing practice license is not renewable. I acknowledge the division's authority to inspect the licensee's business premises pursuant to Utah Code § 58-88-203(4).

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 RDP: _____ Date: _____

For Official Use Only

License Number(s): _____ Expiration: _____

Licensing Specialist: _____ Date of Referral: _____

Notes: _____

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