



California State Board of Pharmacy

1625 N. Market Blvd, N219, Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8617
www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

INSTRUCTIONS FOR FILING AN APPLICATION FOR HYPODERMIC NEEDLE & SYRINGE PERMIT

Permits cannot be transferred to a new location or to new owners. The board must approve any new location or new owner **BEFORE** the change occurs (allow 60 days). Permits are issued for one year, and must be renewed before expiration. Needle and syringes cannot be sold unless the permit is renewed. Failure to renew the permit within 60 days from the expiration date may result in the permit being cancelled. If, after cancellation, needle and syringe sales are to be resumed, a new application (with all documents) must be submitted.

IMPORTANT

Please follow these instructions completely. You must complete and submit all of the requested information. Failure to submit the necessary items will delay the processing of your application. Forms that have been previously submitted with another application cannot be removed from that file (except for fingerprints, see next page).

If the number of forms provided is not sufficient, please make photocopies. You will be notified of any major deficiencies in your application. Please allow approximately 60 days from the time your application is complete before calling the Board of Pharmacy.

If you would like notification that the board has received your application, please submit a stamped postcard addressed to yourself.

The following instructions are divided into 5 sections. Section A lists the requirements for all applicants. Sections B through D list what items are needed from different types of applicant ownership.

**CHECKLIST FOR FILING AN APPLICATION FOR
HYPODERMIC NEEDLE AND SYRINGE PERMIT**

Section A All Applicants

- [] 1. Completed application (17A-15) and the non-refundable processing fee of \$125.
- [] 2. Seller's Certification (17A-16) (If applicable)
This is only required for an application for a change of ownership and it must be submitted by the prospective owner(s).

Section B Individual Owner who is not incorporated

In addition to items listed in Section A, the following must be submitted:

- [] 1. The individual owner must submit:
 - a. Personal Background Affidavit (17A-37)
 - b. Copy of *Request for Live Scan Service Form* verifying that your fingerprints have been scanned and all applicable fees have been paid. Please refer to fingerprint instructions on page 4.

Section C Partnership

In addition to items listed in Section A, the following must be submitted:

- [] 1. Each partner must submit:
 - a. Personal Background Affidavit (17A-37)
 - b. Copy of *Request for Live Scan Service Form* verifying that fingerprints have been scanned and all applicable fees have been paid. Please refer to fingerprint instructions on page 4.
- [] 2. Copy of signed Partnership Agreement.

Section D Corporations

In addition to items listed in Section A, the following items must be submitted:

- [] 1. Each of the top 5 corporate officers, major shareholders and directors must submit:
 - a. Personal Background Affidavit (17A-37)
 - b. Copy of *Request for Live Scan Service Form* verifying that your fingerprints have been scanned and all applicable fees have been paid. Please refer to fingerprint instructions on page 4.
- [] 2. Copy of Articles of Incorporation **endorsed** by the Secretary of State or the applicable tribal government if business is located on a reservation.

Note: Effective January 1, 2001, the Board of Pharmacy requires all applicants for a new license to have not only a California Department of Justice (DOJ) criminal record check but also a federal background check. **No license will be issued without background clearances from both agencies.**

*In order to complete the criminal record check, each out-of-state owner, partner, corporate officer, major shareholder or director must submit rolled fingerprints on cards provided by the board and include a fee of \$49 (\$32 California Department of Justice and \$17 FBI fingerprint processing fee), payable to the Board of Pharmacy. You may contact the board to request fingerprint cards at (916) 574-7900. You may also request cards on our website at www.pharmacy.ca.gov.

Fingerprints should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take approximately six weeks. Poor quality prints may result in rejection and will substantially delay licensing as additional fingerprint cards will be required from you for processing.

Fingerprint Requirements

California Residents

The board will only accept Live Scan Service Forms from California residents.

Complete a Live Scan Request form and take all 3 copies to a Live Scan site for fingerprint scanning. Please refer to the Instructions for completing a "Request for Live Scan Service" form. (Live Scan processing fees are paid directly at the Live Scan site.) Live Scan sites are located throughout California. For more information about locating a Live Scan site near you, visit the Department of Justice website at <http://ag.ca.gov/fingerprints/publications/contact.htm> or the sources listed on the bottom of the instructions for completing a "Request for Live Scan Service" form.

The lower portion of the Live Scan Request form must be completed by the Live Scan operator verifying that your prints have been scanned and all applicable fees have been paid. Attach the second copy of the form to your application and submit to the board.

Non California Residents

If an owner, partner, corporate officer, major shareholder or director reside out of state they must submit rolled fingerprints on cards provided by the board and include a separate fee of \$49 (\$32 California Department of Justice (DOJ) fee and \$17 FBI fingerprint processing fee). You may contact the board to request fingerprint cards at (916) 574-7900. You may also request cards on our website at www.pharmacy.ca.gov.

Fingerprints submitted on cards should be taken by a person professionally trained in the rolling of prints. Fingerprint clearances from cards take approximately six weeks (live scan is faster). Poor quality prints may result in rejection and will substantially delay licensing as additional fingerprint cards will be required from you for processing.

The board will only accept fingerprint cards from residents outside of California.



California State Board of Pharmacy
 1625 N. Market Blvd, Suite N219, Sacramento, CA 95834
 Phone (916) 574-7900
 Fax (916) 574-8618
 www.pharmacy.ca.gov

STATE AND CONSUMERS AFFAIRS AGENCY
 DEPARTMENT OF CONSUMER AFFAIRS
 GOVERNOR EDMUND G. BROWN JR.

APPLICATION FOR HYPODERMIC NEEDLE AND SYRINGE PERMIT

(Please print or type)

Name of Business:		Telephone Number: ()		
Address of Business: Number and Street	City	State	Zip Code	
Indicate type of ownership:				
<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Not-for-profit corporation <input type="checkbox"/> Government owned				
Indicate whether this application is for:				
<input type="checkbox"/> Change of Ownership of an existing Business <input type="checkbox"/> New Business				
If this is a change of ownership or a change of location, indicate below the previous name, address and license number of Hypodermic Needle and Syringe Permit. _____				
Name:		Telephone Number: ()		
Address: Numb er and Street	City	State	Zip Code	
Type of business to be conducted at this location:				
<input type="checkbox"/> Veterinary Supply <input type="checkbox"/> Other: _____				
Hypodermic needle and syringes will be sold or used for what purpose? _____				

Continue on reverse side

For Office Use Only		
<input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Partnership agreement <input type="checkbox"/> Sellers' Cert	Approved _____ Denied _____ Date _____	Cashier # _____ Date _____ Amount _____

Certification of Applicant – Please read carefully and sign below

Under penalty of perjury, under the laws of the state of California, each person whose signature appears below, certifies that: (1) He/she is the applicant, or one of the owners or managers of the applicant corporation, named in the foregoing application, duly authorized to make this application on its behalf; (2) that he/she has read the foregoing application and knows the contents thereof and that each and all statements therein made are true; (3) that no person other than the applicant or applicants has any direct or indirect interest in the applicant's or applicants' business to be conducted under the license(s) for which this application is made, and (4) all supplemental statements are true and accurate.

Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date
Signature of corporate officer, partner or owner	Name (please print)	Title	Date



California State Board of Pharmacy
 1625 N. Market Blvd, Suite N219, Sacramento, CA 95834
 Phone (916) 574-8618
 Fax (916) 574-8618
 www.pharmacy.ca.gov

STATE AND CONSUMER SERVICES AGENCY
 DEPARTMENT OF CONSUMER AFFAIRS
 GOVERNOR EDMUND G. BROWN JR.

SELLER'S CERTIFICATION

INSTRUCTIONS: This form is to be completed by the seller and submitted by the prospective owner with the application for a change of ownership. Attach a copy of the pending purchase agreement.

NOTICE: The current permit is not transferable and the current owner of record must maintain operations and control of the licensed premises (including renewing the permit) until a new application is approved by the Board of Pharmacy. The new owner must complete and attach the new application to this document. (Proof of authority to sell by any person, except a person whose name appears on the original permit, must accompany this certification.)

(Please print or type)

All blanks must be completed; if not applicable enter N/A

This will certify that _____
 (name of individual, partnership* or corporation – “seller”)

has agreed that on _____ “seller” shall transfer _____
 month/day/year (all, half, etc.)

of the right, title and interest in _____
 (name of premises) (permit number)

located at _____
 (street number and name) (city) (state) (zip code)

To _____
 (name of buyer(s))

*IF A PARTNERSHIP, LIST THE NAMES OF ALL PARTNERS (all names must be listed)

On completion of this sale and approval of the new permit, the original permit, and the current renewal must be returned to the California State Board of Pharmacy for cancellation, before the new permit will be released.

Under penalty of perjury under the laws of the State of California, each person whose signature appears below certifies and says that: (1) he/she is the licensee, general partner or an executive officer of the corporate licensee named in this Seller's Certification, duly authorized to make this sale; and (2) all statements made in this Seller's Certification are true and correct to the best of his/her knowledge. If the seller is a partnership, all partners must sign below.

Signature of Seller	Name (please print)	Title	Date
Signature of Seller	Name (please print)	Title	Date
Signature of Seller	Name (please print)	Title	Date



California State Board of Pharmacy
 1625 N. Market Blvd, Suite N219, Sacramento, CA 95834
 Phone (916) 574-7900
 Fax (916) 574-8618
 www.pharmacy.ca.gov

STATE AND CONSUMERS AFFAIRS AGENCY
 DEPARTMENT OF CONSUMER AFFAIRS
 GOVERNOR EDMUND G. BROWN JR.

PERSONAL BACKGROUND AFFIDAVIT

All blanks must be completed; **if not applicable enter "N/A"**. Failure to furnish a complete explanation, or any omissions, will delay the processing of your application.

If fingerprints will be taken outside of California, you must submit one set of two completed fingerprint cards and the fingerprint processing fee of \$49.00. If prints will be taken in California, you must submit a copy of the *Request for Live Scan Service Form* verifying that fingerprints have been scanned and all applicable fees have been paid.

Please print or type

Full name:	Last	First	Middle	Telephone Number:
				()
Address:	Number and Street	City	State	Zip
Date of birth: (MM/DD/YY)	*Social Security number:	Previous name(s) – include maiden name; also known as (AKA's); "aliases":		

Name of applicant (business name):	Applicant telephone number:
Address of applicant: Number and Street City State Zip	

My position with the applicant is: (Check all that apply)

Sole owner Partner Officer Stockholder Member

Other please specify _____

1. Are you currently, or have you in the previous five years, been a manager, administrator, owner, member, officer, director, associate, or partner of any partnership, corporation, firm, or association whose application for a license has been denied or whose license has been revoked, suspended, or been placed on probation in California or any other state? Yes No

If the answer is "yes," please provide the following information for each action taken. Please include cancelled permits. (Use additional sheets if necessary.)

Company Name:	Type of License:	License #:	State:	Position Held:
Type of Action:				Year of Action:

Company Name:	Type of License:	License #:	State:	Position Held:
Type of Action:				Year of Action:

Company Name:	Type of License:	License #:	State:	Position Held:
Type of Action:				Year of Action:

2. Have you ever had a professional or vocational license denied, suspended, revoked, voluntarily surrendered, placed on probation or other disciplinary action taken by this or any other governmental authority in this state, any other state or by a federal regulatory agency? Yes No

If the answer is "yes," please provide company name, permit type, action, year of action and state. (Use additional sheets if necessary.)

Type of License:	License #:	Type of Action:	Year of Action:	State:
Type of License:	License #:	Type of Action:	Year of Action:	State:
Type of License:	License #:	Type of Action:	Year of Action:	State:

3. Have you ever been in violation of any provisions of California pharmacy law, including regulations? Yes No

If "yes," please list each type of violation, license type, type of action, year of action and state. (Use additional sheets if necessary.)

Type of License:	License #:	State:
Type of Action:		Year of Action:

Type of License:	License #:	State:
Type of Action:		Year of Action:

Type of License:	License #:	State:
Type of Action:		Year of Action:

Type of License:	License #:	State:
Type of Action:		Year of Action:

4. Have you ever been convicted of, or pled no contest to, a violation of any law of a foreign country, the United States or of any state or local ordinances? You must include all **misdemeanor and felony convictions**, regardless of the age of the conviction, **including those** which have been set aside and/or dismissed under Penal Code sections 1000 or 1203.4. (Traffic violations of \$500 or less need not be reported.) Yes No

If "yes," please attach the relevant arrest and court documents.

5. Do you currently engage in, or have you been engaged in the past two years in, the illegal use of controlled substances? Yes No

If "yes," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled substances? Please attach a statement of explanation.

Please read carefully and sign below.

I understand that falsification of the information on this form may constitute grounds for denial or revocation of the license.

I hereby certify under penalty of perjury under the laws of the State of California that all statements, answers and representations made in the foregoing personal background affidavit, including all supplementary statements are true and accurate and that I personally completed this personal background affidavit.

Signature

Date

Print Name

Title

*Disclosure of your social security number is mandatory. Business and Professions Code section 30 and Public Law 94-455 (42 USC 405(c)(2)(C) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes of compliance with any judgement or order for family support in accordance with section 11350.6 of the Welfare and Institutions Code, or for verification of examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application for initial or renewal license will not be processed AND you will be reported to the Franchise Tax Board, which may assess a \$100 penalty against you.

NOTICE: Effective July 1, 2012, the State Board of Equalization and the Franchise Tax Board may share individual taxpayer information with the board. You are obligated to pay your state tax obligation. This application may be denied or your license may be suspended if the state tax obligation is not paid.

**INSTRUCTIONS FOR COMPLETING A
"REQUEST FOR LIVE SCAN SERVICE" FORM
(California Residents)**

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly; failure to do so may result in processing delays of your application.

NOTE TO APPLICANT and LIVE SCAN OPERATOR: The applicant's name, date of birth, and US social security number must be entered in at the time of the Live Scan transmission in order for the results to be accepted by the Board of Pharmacy. If any of the required information indicated below is not entered at the time of Live Scan transmission, the applicant may be required to have a new Live Scan transmission completed.

REQUIRED INFORMATION

- **Type of License/Certification/Permit OR Working Title:** It is important that you print out the Live Scan form that goes with your application, as this information is already entered on the form for you. It is important that the Live Scan operator types in this information exactly into their system or at least the numeric section.
- **Name:** Print your name as it appears on your U.S. government photo identification (ID). The name on your ID must match identically to the name you enter on your application. If you change your name, you are required to notify the board within 30 days of the change.
- **Other Name (AKA):** Include all other names you have used, including your maiden name.
- **Date of Birth:** (month/day/year).
- **SEX:** Mark the appropriate gender box (male or female)
- **Driver's License Number:** California Driver's License Number.
- **Height:** Your height in feet and inches.
- **Weight:** Your weight in pounds.
- **Eye Color:** Color of your eyes
- **Hair Color:** Color of your hair
- **Place of Birth:** State or County
- **Social Security Number (Mandatory):** Your US Social Security Number. It is your responsibility to notify the Live Scan operator that your US social security number is mandatory to be included in the submission for the Board of Pharmacy. Failure to ensure that your social security number is included on the submission will result in you having to be refingerprinted and pay all fees associated with the processing of your fingerprints.
- **Misc. Number:** Other identification number
- **Home Address:** Your residence address
- **Level of Service:** While the Live Scan forms contained in the board's application package are pre-slugged to indicate level of service at the DOJ and FBI level, please ensure at the time of Live Scan transmission that the Live Scan operator selects both the DOJ and FBI levels of service. If FBI is not selected at the time of original transmission, you may be required to have your Live Scan redone at another time and have to repay for the DOJ and FBI levels of services again. The board has been notified by the DOJ that effective 9/1/07; if the FBI level of service is not requested at the time of original transmission both DOJ and FBI levels of service will have to be redone. Any issue of cost for resubmission should be handled at the Live Scan Site level.

Take the completed form to your nearest Live Scan site for fingerprint scanning. There are more than 130 Live Scan sites throughout the state. An up-to-date Live Scan site list is on the Department of Justice's (DOJ) Internet web page at <http://ag.ca.gov/fingerprints/publications/contact.htm> or call your local police or sheriff's department.

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (DOJ processing fee of \$32, FBI processing fee of \$17, and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about \$5 to \$20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs. The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. Please print three copies of the Request for Live Scan Service form. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

FINGERPRINTING AUTHORITY

Section 144(b) of the Business and Professions Code authorizes the Board of Pharmacy to require an applicant for licensure to furnish a full set of fingerprints for purposes of conducting criminal history record checks. Fingerprints are required in order for the DOJ/FBI to conduct background checks for criminal convictions.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: _____ Type of Application: (check one) Employment License, Certification, Permit Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

Agency authorized to receive criminal history information _____ Mail Code (five-digit code assigned by DOJ) _____
Street No. _____ Street or PO Box _____ Contact Name (Mandatory for all school submissions) _____
City _____ State _____ Zip Code _____ () _____
Contact Telephone No. _____

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____ CDL No. _____
Last First

DOB: _____ SEX: Male Female Misc. No. **BIL** - _____
Agency Billing Number (if applicable)

HT: _____ WT: _____ Misc. No. _____

EYE Color: _____ HAIR Color: _____ Home Address: _____

POB: _____ Street or PO Box _____

SOC: _____ City, State and Zip Code _____

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ FBI

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

Employer Name _____

Street No. _____ Street or PO Box _____ Mail Code (five digit code assigned by DOJ) _____

City _____ State _____ Zip Code _____ () _____
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency _____ ATI No. _____ Amount Collected/Billed _____

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: _____ Type of Application: (check one) Employment License, Certification, Permit Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

Agency authorized to receive criminal history information _____ Mail Code (five-digit code assigned by DOJ) _____
Street No. _____ Street or PO Box _____ Contact Name (Mandatory for all school submissions) _____
City _____ State _____ Zip Code _____ () _____
Contact Telephone No. _____

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____ CDL No. _____
Last First

DOB: _____ SEX: Male Female Misc. No. **BIL** - _____
Agency Billing Number (if applicable)

HT: _____ WT: _____ Misc. No. _____

EYE Color: _____ HAIR Color: _____ Home Address: _____

POB: _____ Street or PO Box _____

SOC: _____ City, State and Zip Code _____

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ FBI

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

Employer Name _____

Street No. _____ Street or PO Box _____ Mail Code (five digit code assigned by DOJ) _____

City _____ State _____ Zip Code _____ () _____
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency _____ ATI No. _____ Amount Collected/Billed _____

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: _____ Type of Application: (check one) Employment License, Certification, Permit Volunteer
Code assigned by DOJ
Job Title or Type of License, Certification or Permit: _____

Agency Address Set Contributing Agency:

Agency authorized to receive criminal history information _____ Mail Code (five-digit code assigned by DOJ) _____
Street No. _____ Street or PO Box _____ Contact Name (Mandatory for all school submissions) _____
City _____ State _____ Zip Code _____ () _____
Contact Telephone No. _____

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____ CDL No. _____
Last First

DOB: _____ SEX: Male Female Misc. No. **BIL** - _____
Agency Billing Number (if applicable)

HT: _____ WT: _____ Misc. No. _____

EYE Color: _____ HAIR Color: _____ Home Address: _____

POB: _____ Street or PO Box _____

SOC: _____ City, State and Zip Code _____

Your Number: _____
OCA No. (Agency Identifying No.)

Level of Service DOJ FBI

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

Employer Name _____

Street No. _____ Street or PO Box _____ Mail Code (five digit code assigned by DOJ) _____

City _____ State _____ Zip Code _____ () _____
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency _____ ATI No. _____ Amount Collected/Billed _____