CHECKLIST FOR FILING A NONRESIDENT OUTSOURCING FACILITY APPLICATION

Use the checklist below to assist in completing the nonresident outsourcing facility application and to provide the required supporting documents for the applicant business' ownership structure.

Section A Nonresident Outsourcing Facility Application (All Applicants)

All applicants are required to complete and submit the following:

☐ **Nonresident Outsourcing Facility Application** (17A-91)**:** Complete the entire application and submit with original signatures.
- **Do Not Leave Blanks:** If an item or question is not applicable, indicate N/A.
- **Doing Business As (DBA)**: If using a DBA, submit a Fictitious Business Name Statement.

☐ **Application Processing Fee $2,380:** Include a check or money order for $2,380 made payable to the Board of Pharmacy. This fee is nonrefundable.
- To apply for a temporary license, an additional fee of $715 must be submitted in addition to the application processing fee. If other than a change of ownership and/or location, include a written letter signed by the owner / partner / officer / member that clearly explains why it is in the best interest of the public for the board to issue the facility a temporary license.

☐ **Organizational Chart:** Submit a business ownership organizational chart that clearly documents the applicant business' ownership structure with the application. Include percentages owned by all parties and lists the executive officers under the appropriate entity.

☐ **Inspection Reports:** Copies of all federal and state regulatory agency inspection reports, as well as accreditation reports, and certification reports of facilities or equipment of the outsourcing facility's premises conducted in the prior 12 months.

- **Drug List:** The most recent list of all sterile drugs and nonsterile drugs compounded by the facility as reported to the FDA in the last 12 months.

- **Policies and Procedures:** Current copy of the outsourcing facility's policies and procedures for sterile compounding and nonsterile compounding. The policies and procedures may be submitted electronically to the following e-mail address - - compounding.pharmacy@dca.ca.gov. Please include the FDA Registration Number in the e-mail.

Section B Change of Ownership / Change of Location

A nonresident outsourcing facility license is nontransferable. A license is issued to the owner(s) and to the location of the facility. A change of ownership and/or change of location result in a new license number being issued to the new owner(s) and/or location. An application to the board and approval by the board should be submitted prior to the change occurring. Operating the facility prior to being issued a new license due to a change of ownership and/or location may be unlicensed activity.

In addition to the application requirements in Sections A, C, and D submit the following for a change of ownership application.

☐ **Change of Ownership Documentation:** Provide all required documents as listed in the appropriate ownership business in Section C, including but not limited to:
- Seller's Certification (17A-8)
- Copy of the signed proposed purchase agreement.
- A copy of the final sale/closing documents will need to be submitted prior to the issuance of the license by the applicant applying for the nonresident outsourcing license.
- Organizational Chart: Submit a business ownership organizational chart that clearly documents the applicant's business ownership structure with the application. Include both the pre- and post-business ownership structure.

Section C Nonresident Outsourcing Ownership Documents (All Applicants)

C1 - Individual Owner (Sole Proprietor)

In addition to items listed in Sections A and D submit the following:

☐ The individual owner needs to complete and submit a Personal Background Affidavit (17A-37)

C2 – Partnership

In addition to items listed in Sections A and D submit the following:

☐ Personal Background Affidavit (17A-37):
- Partner(s)
- Executive officer(s)
  (If the applicant business does not hold executive officers, list the executive officers for the parent entity or the entity above the parent which holds the executive officers. The executive officer(s) must be identified by name and officer title on the organizational chart.)

☐ Business Background Affidavit (17A-18):
- The applicant business
- The parent entity(ies)

☐ Partnership Agreement: Current executed partnership agreement for the applicant business.

C3 – Corporation (Not Publicly Traded)

In addition to items listed in Sections A and D submit the following:

☐ Personal Background Affidavit (17A-37):
- Executive officer(s)
  (If the applicant business does not hold executive officers, list the executive officers for the parent entity or the entity above the parent which holds the executive officers. The executive officer(s) must be identified by name and officer title on the organizational chart.)

☐ Business Background Affidavit (17A-18):
- The applicant business
- The parent entity(ies)

☐ Articles of Incorporation: Submit a copy of the Articles of Incorporation filed with the Secretary of State for the applicant business bearing the Secretary of State's stamp (proof of filing).

☐ Statement of Information: A copy of the current filing with the Secretary of State bearing the Secretary of State stamp or equivalent governmental document (e.g. annual report) that discloses the current officer(s) on file for the entity.

☐ Stock Certificates and Stock Ledger: Provide a copy of stock certificate(s) front and back along with a copy of the stock ledger, if stocks are issued. If stocks are not issued, please provide a statement that states as such.

☐ Bylaws: Provide a copy of the bylaws or internal operating rules for the applicant business.

C4 – Publicly Traded Corporation

In addition to items listed in Sections A and D submit the following:

☐ Personal Background Affidavit (17A-37):
- Executive officer(s)

☐ Business Background Affidavit (17A-18):
- The applicant business

☐ Corporation's 10K Filing: Include a copy of the document filed with the Securities Exchange Commission.

C5 – Limited Liability Company

In addition to items listed in Sections A and D submit the following:

- ☐ Personal Background Affidavit (17A-37):
  - Member(s)
  - Executive officer(s)
    (If the applicant business does not hold executive officers, list the executive officers for the parent entity or the entity above the parent which holds the executive officers. The executive officer(s) must be identified by name and officer title on the organizational chart.)
- ☐ Business Background Affidavit (17A-18):
  - The applicant business
  - The parent/member entity(ies)
- ☐ Articles of Organization: Submit a copy of the Articles of Organization filed with the Secretary of State for the applicant business.
- ☐ Statement of Information: A copy of the current filing with the Secretary of State bearing the Secretary of State stamp or equivalent governmental document (e.g. annual report) that discloses the current officer(s) on file for the entity.
- ☐ Operating Agreement: Current business operating agreement for the applicant business.

C6 – Trust

In addition to items listed in Sections A and D submit the following:

- ☐ Personal Background Affidavit (17A-37):
  - Trustee(s)
- ☐ Business Background Affidavit (17A-18):
  - The applicant business
- ☐ Trust Document: Provide a copy of the trust or documentation signed under penalty of perjury by the authorized representative of the trust that lists the name(s) of the trustee(s) and beneficiaries, including the percentages of their interest in the trust.

Section D Fingerprints

Each person who is required to complete a Personal Background Affidavit (as instructed in Section C) is required to complete the Live Scan or submit the board approved fingerprint cards for a criminal background check with the Department of Justice (DOJ) and Federal Bureau of Investigation (FBI). *If a person is currently associated with an active license and has electronic fingerprints already on file with the California State Board of Pharmacy, new fingerprints may not be required.*

Effective July 1, 2018, ALL applicants including nonprofit organizations must complete the fingerprint requirement.

Fingerprint Instructions: Complete and attach **ONE** of the following (either A or B):

- California residents must use Live Scan. Nonresidents can visit California to complete a Live Scan or must submit professionally rolled fingerprints on cards supplied by the board.
- DO NOT complete the Live Scan service or fingerprint cards until the applicant is ready to send in the application.
- The Live Scan site may charge a processing fee.
- Fingerprint card processing fee is $49 per person ($32 DOJ and $17 FBI) made payable to the Board of Pharmacy.
- The board will accept fingerprint responses only from the California Department of Justice (DOJ) and Federal Bureau of Investigation (FBI).

A. California Resident: Attach a copy of the completed Live Scan receipt. The receipt verifies that the individual being fingerprinted has completed the Live Scan process and provides tracking information. It is

the responsibility of the individual being fingerprinted to verify that all personal information entered by the Live Scan operator is correct prior to the operator's submission. The Board of Pharmacy will not accept clearances by the DOJ/FBI if the personal information is incorrect. Receipt of incorrect information by the DOJ/FBI will result in the individual having to complete a new Live Scan.

- California residents must use Live Scan only.
- To find a Live Scan location, go to https://oag.ca.gov/fingerprints/locations
- The individual being fingerprinted must ensure the following information is correct when completing the Live Scan:
  - **Type of License/Certification/Permit or Working Title:** Outsourcing Fac- 4201BP
  - **Full Name:** Must be EXACTLY THE SAME as the individual's name on his/her state-issued driver's license or state-issued identification card (Jr., II, etc., must be included). It also must be EXACTLY THE SAME as the individual's name on the application.
  - **Date of Birth:** Do not omit. If left blank, he/she may have to reprint.
  - **Social Security Number (SSN):** If left blank, he/she may have to reprint.
  - **Level of Service:** Must include both DOJ and FBI.

B. Non-California Resident: The individual being fingerprinted may visit California and complete Live Scan. If he/she cannot complete the Live Scan, then two rolled fingerprint cards must be submitted with the application for each individual being fingerprinted.

- Only fingerprint cards provided by the Board of Pharmacy will be accepted.
- Request fingerprint cards through the board's online services at https://www.dca.ca.gov/webapps/pharmacy/pubs_request.php or via email to rxforms@dca.ca.gov.
- Fee: Include fingerprint card processing fee of $49 for each individual being fingerprinted ($32 DOJ and $17 FBI) made payable to the Board of Pharmacy. You may submit one check or money order for both the application processing fee and fingerprint card processing fee(s).
- Print legibly or type personal information on the fingerprint cards. If the personal information of the individual being fingerprinted is not legible and DOJ enters the information incorrectly, he/she will be responsible to submit new fingerprint cards and pay the $49 fingerprint card processing fee again. DOJ will NOT correct print results due to illegible fingerprint cards.
- Fingerprints must be taken by a person professionally trained to roll fingerprints.
- Fingerprint clearances from cards take approximately six weeks.
- Poor quality prints will be rejected by DOJ/FBI and will cause delay because new fingerprint cards will be required.

California State Board of Pharmacy
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BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GAVIN NEWSOM, GOVERNOR

NONRESIDENT OUTSOURCING FACILITY LICENSE APPLICATION

I. Applicant Business Information *Please print or type*

Name of Nonresident Outsourcing Facility as it will appear on the License – may include DBA (Cannot exceed 65 characters including spaces):
Legal Name of Nonresident Outsourcing Facility Business:
Location of Business: Number and Street City State Zip Code

FDA Registration Number:	Telephone Number of Applicant Business: ( )

II. Application Type Check all that apply and attach appropriate fee(s).

- ☐ New Nonresident Outsourcing Facility License Anticipated Opening Date: _____
- ☐ Change of Ownership Anticipated Change of Ownership Date: _____
- ☐ Change of Physical Location Anticipated Move Date: _____
- ☐ Temporary License Request – Additional fee required

III. Change of Ownership or Location

Name on Current Nonresident Outsourcing Facility License:	License Number and Expiration Date:
Address:	Effective Date of Change of Ownership/Move:

IV. Type of Ownership

☐ Individual ☐ Partnership ☐ Corporation (not publicly traded) ☐ Publicly Traded ☐ Limited Liability Company ☐ Trust ☐ Government

V. FEIN # (Federal Employer ID #)

VI. Applicant Business Operations

1. Does your facility compound patient specific drugs? ☐ YES ☐ NO
2. Does your facility compound from bulk drug substances? ☐ YES ☐ NO
   If yes please indicate the type(s) of compounding performed ☐ Sterile ☐ Nonsterile ☐ Both Sterile and Nonsterile

VII. Contact person for this application.

The board will ONLY discuss the status of this application with the person identified as the contact person and any person who has signed the application as an officer, partner, member, and/or owner of the applicant business. An authorized owner may designate additional individuals to receive information on this pending application by submitting the Authorization to Release Applicant Information form.

Name:			Telephone:
Mailing Address: Number and Street	City	State	Zip Code
Email Address:			

For Office Use Only

Date Processed: _____ By:_____ Date Sent to 2LR:_____ By:_____ Date 2LR reviewed: _____ By: _____	Date Issued: _____ By: _____ Post Issuance: _____ By_____	Cashier #: _____ Date: _____ Amount: _____

VIII. Ownership Information

California Business and Professions Code section 4035 specifies “person" includes firm, association, partnership, corporation, limited liability company, state governmental agency, trust, or political subdivision.

The application shall provide information to identify the ownership of the applicant business. This may include a parent company as well as each officer, partner and member (as appropriate) for the applicant business. Please provide an organizational chart that clearly documents the applicant business’ ownership structure, including percentages owned by all parties.

Complete and submit a Business Background Affidavit (17A-18) for an entity listed in Section VIII signed by its authorized agent. Any natural person listed in Section VIII needs to complete and submit a Personal Background Affidavit (17A-37).

The board may require additional documentation to confirm or substantiate the reported ownership structure at any time during the application process.

Entities:

If the applicant business is owned by an entity (not a natural person), identify each parent entity that has beneficial interest and has management and control of the applicant business, and identify its authorized agent. The authorized agent shall be an officer, partner, member, owner, or trustee of the parent business who is authorized to bind the business.

Name of Partnership (attach additional sheets if necessary):			% of ownership	Telephone Number ( )
Address:	Number and Street	City	State	Zip Code
Name of Authorized Agent:			Authorized Agent telephone number:	
Name of Partner 1:			% of ownership	Telephone Number ( )
Address:	Number and Street	City	State	Zip Code
Name of Authorized Agent:			Authorized Agent telephone number:	
Name of Partner 2:			% of ownership	Telephone Number ( )
Address:	Number and Street	City	State	Zip Code
Name of Authorized Agent:			Authorized Agent Telephone Number:	
Name of Corporation:			% of ownership	Telephone Number ( )
Address:	Number and Street	City	State	Zip Code
Name of Authorized Agent:			Authorized Agent Telephone Number:	
Name of Limited Liability Company:			% of ownership	Telephone Number ( )
Address:	Number and Street	City	State	Zip Code
Name of Authorized Agent:			Authorized Agent Telephone Number:	
Name of Government Agency or Trust:			% of ownership	Telephone Number ( )
Address:	Number and Street	City	State	Zip Code

Natural Person(s):

Provide the name(s) of each owner, partner, member, stockholder, trustee, or administrator (government owned) who is a natural person of the applicant business. If there are no natural person(s) under the applicant business, list the owner(s), partner(s), member(s), stockholder(s), trustee(s), or administrator (government owned) who are natural persons for the parent business as listed in the Entities section. Natural persons identified shall be authorized to act for and bind the applicant business.

Name:	Position Title	% of ownership	Telephone Number ( )
Address: Number and Street	City	State	Zip Code

Name:	Position Title	% of ownership	Telephone Number ( )
Address: Number and Street	City	State	Zip Code

Name:	Position Title	% of ownership	Telephone Number ( )
Address: Number and Street	City	State	Zip Code

Name:	Position Title	% of ownership	Telephone Number ( )
Address: Number and Street	City	State	Zip Code

Name:	Position Title	% of ownership	Telephone Number ( )
Address: Number and Street	City	State	Zip Code

IX. Executive Officer(s) Information

Provide the name(s) of the top five executive officer(s) for the applicant business. If there are no officers of the applicant business, list the top five officer(s) for the parent business as listed in the Entities section.

Name:	Position Title	% of ownership	Telephone Number ( )
Address: Number and Street	City	State	Zip Code

Name:	Position Title	% of ownership	Telephone Number ( )
Address: Number and Street	City	State	Zip Code

Name:	Position Title	% of ownership	Telephone Number ( )
Address: Number and Street	City	State	Zip Code

Name:	Position Title	% of ownership	Telephone Number ( )
Address: Number and Street	City	State	Zip Code

Name:	Position Title	% of ownership	Telephone Number ( )
Address: Number and Street	City	State	Zip Code

X. Background Information

List ALL states/territories in which the applicant business is or has been licensed as a wholesaler, pharmacy, third-party logistics provider, manufacturer, outsourcing facility or re-packager. If the applicant business does not hold any other license, please indicate None. ***Use additional copies of page 5, if needed. Do not indicate "see attached."***

If there has been any disciplinary action taken against any of the licenses listed below, a written explanation giving full details of the action taken MUST be provided with the application.

State	License Type/Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	Yes ☐ No ☐
State	License Type/Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	Yes ☐ No ☐
State	License Type/Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	Yes ☐ No ☐
State	License Type/Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	Yes ☐ No ☐
State	License Type/Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	Yes ☐ No ☐
State	License Type/Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	Yes ☐ No ☐
State	License Type/Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	Yes ☐ No ☐
State	License Type/Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	Yes ☐ No ☐
State	License Type/Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	Yes ☐ No ☐
State	License Type/Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	Yes ☐ No ☐
State	License Type/Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	Yes ☐ No ☐
State	License Type/Number	Issue Date	Has any disciplinary or criminal action been taken against this license?	Yes ☐ No ☐

XI. Person or Agency located in California that will act as an agent for service of process.

Name:				Telephone:
Mailing Address:	Number and Street	City	State	Zip Code
Email Address:				

APPLICANT AFFIDAVIT - Read carefully and sign below

This application must be approved by the California State Board of Pharmacy before an outsourcing facility license will be issued. The applicant outsourcing facility shall not conduct business in California until a license is issued. If changes are made during the application process, the applicant may need to submit a new application with appropriate fees**. Any application not completed within 60 days after being notified by the board of deficiencies, may be deemed to have been abandoned, and the applicant may be required to file a new application and meet all the requirements which are in effect at the time of application. Fees applied to this application are not transferable and are not refundable.**

Failure to provide any of the requested information may result in the application being considered incomplete. Any material misrepresentation in the answer of any question may constitute grounds for denial or subsequent revocation of license and a violation of the California Penal Code.

The information will be used to determine qualifications for licensure under the California Pharmacy Law. The official responsible for maintaining records is the Executive Officer at the board's address listed on the application. The information may be transferred to another governmental agency, such as a law enforcement agency, if necessary to perform its duties. Each individual has the right to review the files or records maintained by the board, unless confidential and exempt by law.

NOTICE: 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.

ALL OWNERS AND OFFICERS SIGN BELOW: This includes the authorized agent for the entity ownership as well as the individual owner, partners, executive officer(s), member(s), manager(s), trustee(s), and administrator (government owned) listed on the application. Provide original signatures. Scanned, stamped or electronic signatures may not be accepted.

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 owner, partner, member, officer, manager, trustee, or the Administrator (government owned) of the applicant business named in the foregoing application, duly authorized to make this application on its behalf and is at least 18 years of age;
2) He/she has read the foregoing application and knows the contents thereof and attests to the truth and accuracy of all statements, answers, and representations made in this application, including all supplementary statements.;
3) No person other than the applicant or applicants has any direct or indirect interest or management and control in the applicant outsourcing facility to be conducted under the license for which this application is made;
4) He/she understands that falsification of any information in this application may constitute grounds for denial or subsequent revocation of the license; and
5) A change of ownership application may be withdrawn by either the applicant or the licensee with no resulting liability to the California State Board of Pharmacy.

Signature of owner, partner, member, executive officer, manager, trustee, or Administrator	Name (please print)	Title	Date
Signature of owner, partner, member, executive officer, manager, or trustee	Name (please print)	Title	Date
Signature of owner, partner, member, executive officer, manager, or trustee	Name (please print)	Title	Date
Signature of owner, partner, member, executive officer, manager, or trustee	Name (please print)	Title	Date
Signature of owner, partner, member, executive officer, manager, or trustee	Name (please print)	Title	Date

AUTHORIZATION TO RELEASE APPLICANT INFORMATION

(Optional)

Applicant Business Information *Please print or type*

Name of Business:				Telephone Number of Business: ( )
Name of Business DBA if different than above				
Address of Business:	Number and Street	City	State	Zip Code

The board will ONLY discuss the status of this application with the authorized person identified on the application and any person who has signed the application as an officer, partner, member, and/or owner of the applicant business. In order for the board to discuss the status of this application with another individual, the authorized person identified on the application must authorize in writing the board to discuss the application status with a his or her authorized representative.

Giving consent for the board to disclose application and business information will authorize the board to disclose all personal and business information pertaining to this application. This includes but is not limited to social security number, date of birth, address information, all application requirement information, application approval or denial status, and any criminal conviction information the board may have on record for your application.

APPLICANT CONSENT

(must be signed and dated by the applicant for optional authorization to be valid)

As a person identified on the application that is authorized to act for and bind the applicant business, I hereby give the board consent to communicate to the individual listed below.

I, _____, hereby give consent to
Print Name of Person Authorized to Bind the Applicant Business

the California State Board of Pharmacy to disclose information about this application as specified above to the following individual:

Name:			Telephone:
Mailing Address:	Street	City	State Zip
E-mail Address:			

This consent will expire on _____ , within one year, or upon licensure, whichever comes first.
(Date)

_____ _____
Original Signature of Person Authorized to Bind the Applicant Business Date

2. Has this business ever been in violation of any provisions of California pharmacy law, including regulations? Yes ☐ No ☐

   If "yes," list each type of violation, license type, type of action, year of action and state. (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:

3. Has this business 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 1210.1 or 1203.4. Yes ☐ No ☐

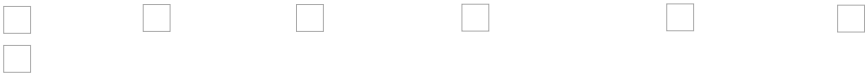
Applicant Affidavit

Please read carefully and sign below.

I hereby certify and affirm under penalty of perjury, under the laws of the State of California, that: (1) I am a person authorized to act for and bind the applicant and I am at least 18 years of age; (2) I have read the foregoing background certification and know the contents thereof and each and every statement made therein is true; (3) I understand that falsification of any information in this affidavit may constitute grounds for denial or subsequent revocation of the license; (4) no other 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 for which this affidavit is made; all supplemental statements filed with this affidavit are true, complete and accurate.

Original Signature of Authorized Person or Agent — Date

Print Name — Title



Ownership Information - For any affirmative answer, attach a statement of explanation including company name, type of license, license number, and identify the state, territory, foreign country, or other jurisdiction where licensed. 1. Are you currently or have you previously been listed as a corporate officer, partner, owner, manager, member, administrator, or medical director on a license to conduct a pharmacy, wholesaler, third-party logistics provider, or any other entity licensed in any state, territory, foreign country, or other jurisdiction?	1. Yes ☐ No☐
Disciplinary History – The following questions pertain to a license sought or held in any state, territory, foreign country, or other jurisdiction. For any affirmative answer, attach a statement of explanation including type of license, license number, type of action, date of action, and identify the state, territory, foreign country, or other jurisdiction. 2. Have you ever had an application for pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration denied?	2. Yes ☐ No☐
3. Have you ever had a pharmacy technician, intern pharmacist, pharmacist, any type of designated representative, and/or any other professional or vocational license or registration suspended, revoked, placed on probation, or had other disciplinary action taken against it?	3. Yes ☐ No☐
4. Have you ever been associated with a pharmacy, wholesaler, third-party logistics provider, and/or any other entity whose license was denied, suspended, revoked, placed on probation, or had other disciplinary action taken against a license you hold?	4. Yes ☐ No ☐
5. Have you ever been in violation of any provisions of pharmacy law, in this or any other state?	5. Yes ☐ No ☐
Practice Impairment or Limitation The board makes an individualized assessment of the nature, the severity, and the duration of the risks associated with any identified condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether the applicant is not qualified for licensure. If the board is unable to make a determination based on the information provided, the board may require an applicant to be examined by one or more physicians or psychologists, at the board's cost, to obtain an independent evaluation of whether the applicant is able to safely practice despite the mental illness or physical illness affecting competency. A copy of any independent evaluation would be provided to the applicant. **For any affirmative answer, attach a statement of explanation.** 6. Have you ever been diagnosed with an emotional, mental, or behavioral disorder that may impair your ability to practice safely?	6. Yes ☐ No ☐
7. Have you ever been diagnosed with a physical condition that may impair your ability to practice safely?	7. Yes ☐ No ☐
8. Do you have any other condition that may in any way impair or limit your ability to practice safely?	8. Yes ☐ No ☐
9. Have you ever participated in, been enrolled in, or required to enter into any drug, alcohol, or substance abuse recovery program or impaired practitioner program?	9. Yes ☐ No ☐
10. If you answered "Yes" to questions 6 through 9 above, have you ever received treatment or participated in any program that improves your ability to practice safely?	10.Yes ☐ No ☐ N/A ☐

Criminal Record History

Applicants who answer "**No"** to the questions below, but have a previous conviction or plea, may have their application denied for knowingly falsifying the application. If in doubt as to whether a conviction should be disclosed, it is best to disclose the conviction on the application.

To assist in the timely processing of your application, for each conviction, submit: 1) certified copies of the arresting agency records, 2) certified copies of the court documents (court docket), 3) a signed and dated descriptive explanation of the circumstances surrounding the conviction (i.e., dates and location of the incident and all circumstances surrounding the incident), and 4) proof of compliance with probation or parole. If the documents were purged by the arresting agency and/or court, a letter of explanation from these agencies is recommended. In addition, you may submit evidence of rehabilitation or any information you deem appropriate.

11. **Have you EVER been convicted of, or pleaded guilty or nolo contendere/no contest to, ANY crime, in any state, the United States or its territories, a military court, or any foreign country?** 11. Yes ☐ No☐

This includes any felony or misdemeanor offense and any infraction. You must disclose a conviction even if it was: (1) later dismissed or expunged pursuant to Penal Code section 1203.4 or an equivalent release from penalties and disabilities provision from a non-California jurisdiction, or (2) later dismissed or expunged pursuant to Penal Code section 1210.1 or an equivalent post-conviction drug treatment diversion dismissal provision from a non-California jurisdiction.

NOTE: You may answer "No" regarding, and need not disclose, any of the following: (1) criminal matters adjudicated in juvenile court; (2) criminal charges dismissed or expunged pursuant to Penal Code section 1000.4 or an equivalent deferred entry of judgment provision from a non-California jurisdiction; (3) convictions for violations of Health and Safety Code section 11357, subdivisions (b), (c), (d), or (e), or Health and Safety Code section 11360, subdivision (b), that are more than two years old on the date you sign your application; and (4) traffic violations that do not involve drugs or alcohol.

Arrest Date	Conviction Date	Violation(s)	Case #	Court of Jurisdiction (Full Name and Address)

12. **Is any criminal action pending against you, or are you currently awaiting judgment and sentencing following entry of a plea or jury verdict?** 12. Yes ☐ No☐

Arrest Date	Violation(s)	Case #	Court of Jurisdiction (Full Name and Address)

APPLICANT AFFIDAVIT - Please read carefully and sign below.

Please provide a written explanation for all affirmative answers. Failure to provide any of the requested information may result in the application being deemed incomplete. Falsification of the information on this application may constitute grounds for denial or revocation of the license.

This information will be used to determine qualifications for licensure under California pharmacy law. The officer responsible for information maintenance is the executive officer, telephone (916) 574-7900, 1625 N. Market Blvd., Suite N219, Sacramento, CA 95834. This information may be transferred to another governmental agency, such as a law enforcement agency, if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted by Civil Code section 1798.3.

****Disclosure of your U.S. social security number or Individual Taxpayer Identification Number (ITIN) is mandatory.** Section 30 of the Business and Professions Code, section 17520 of the Family Code, and Public Law 94-455 (42 USC § 405(c)(2)(C)) authorize collection of your social security number or individual taxpayer identification number. Your social security number or individual taxpayer identification number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for child or family support in accordance with section 17520 of the Family Law Code, or for verification of license or examination status by a licensing or 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 or individual taxpayer identification number, your application will not be processed, and you may be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

NOTICE: The State Board of Equalization and the Franchise Tax Board may share 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 your state tax obligation is not paid.

I hereby certify under penalty of perjury under the laws of the State of California to the truth and accuracy of 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. I understand that my application may be denied, or any license disciplined, for fraud or misrepresentation.

_____

Original Signature of Applicant (please sign and date within 60 days of board receipt of the application) Date

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 or individual taxpayer identification 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:** Enter your name as it appears on your U.S. government photo identification. If you change your name, you are required to notify the board within 30 days of the change.
- **Other Name (AKA):** Enter 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:** Enter your place of birth
- **Social Security Number (Mandatory):** Enter your US Social Security Number or individual taxpayer identification number
- **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.php 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.

STATE OF CALIFORNIA
BCII 8016
(orig. 4/01; rev. 6/09)

DEPARTMENT OF JUSTICE

REQUEST FOR LIVE SCAN SERVICE

Print Form Reset Form

Applicant Submission

A0071
ORI (Code assigned by DOJ)

License/Cert/Permit
Authorized Applicant Type

Nonres Outsrc Fac 4201 BP
Type of License/Certification/Permit OR Working Title (Maximum 30 characters - if assigned by DOJ, use exact title assigned)

Contributing Agency Information:

Board of Pharmacy
Agency Authorized to Receive Criminal Record Information

05712
Mail Code (five-digit code assigned by DOJ)

1625 N. Market Blvd, Suite N219
Street Address or P.O. Box

Licensing
Contact Name (mandatory for all school submissions)

Sacramento
City

95834
State ZIP Code

(916) 574-7900
Contact Telephone Number

Applicant Information: **Live Scan Operator – The Board of Pharmacy requires you to enter the applicant's SSN.**

Last Name

First Name Middle Initial Suffix

Other Name (AKA or Alias)
Last

First Suffix

Date of Birth

Sex ☐ Male ☐ Female

Driver's License Number

Height Weight Eye Color Hair Color

Billing Number: Applicant Must Pay Fees
(Agency Billing Number)

Place of Birth (State or Country)

Social Security Number - **MANDATORY**

Misc. Number
(Other Identification Number)

Home Address
Street Address or P.O. Box

City State ZIP Code

Your Number: N/A
OCA Number (Agency Identifying Number)

Level of Service: ☒ DOJ ☒ FBI

If re-submission, list original ATI number:
(Must provide proof of rejection)

Original ATI Number

Employer (Additional response for agencies specified by statute):

N/A
Employer Name

N/A
Mail Code (five digit code assigned by DOJ

N/A
Street Address or P.O. Box

N/A
City State ZIP Code

N/A
Telephone Number (optional)

Live Scan Transaction Completed By:

Name of Operator

Date

Transmitting Agency LSID ATI Number Amount Collected/Billed

ORIGINAL - Live Scan Operator SECOND COPY - Applicant THIRD COPY (if needed) - Requesting Agency