AGENDA

Florida Board of Pharmacy
Rules Committee Meeting
January 12, 2018 – 1:00 p.m.

Telephone Number: 888-670-3525
Participant Code: 5134896685

Committee Members:
Jeffrey Mesaros, PharmD, JD – Chair
David Bisaillon
Jeenu Philip, BPharm

Board Staff
C. Erica White, MBA, JD - Executive Director
Irene Lake, Program Operations Administrator

Board Counsel:
David Flynn, Assistant Attorney General
Lawrence Harris, Assistant Attorney General

Note: Participants in this public meeting should be aware that these proceedings are being recorded.

1. **Rule 64B16-27.450, F.A.C.** – Prescription Department Managers

2. **Rule 64B16-28.501, F.A.C.** – Institutional Permit – Consultant Pharmacist of Record

3. **Rule 64B16-28.100 F.A.C.** – Pharmacy Permits – Applications and Permitting (rule revisions)

4. **Rule 64B16-28.100, F.A.C., and Amendments to Pharmacy Permit Applications:**
   - Community Pharmacy Permit – DH MQA 1214
   - Institutional Pharmacy Permit – DH MQA 1215
   - Nuclear Pharmacy Permit – DH MQA 1218
   - Special Pharmacy Permit – DH MQA 1220
   - Special Sterile Compounding Pharmacy Permit – DH MQA 1270
   - Internet Pharmacy Permit – DH MQA 1216
   - Change in Prescription Department Manager - DH-PH10
   - Change in Consultant Pharmacist of Record - DH-MQA 1184

5. **Old Business / New Business**

6. **Public Comment**

7. **Adjourn**

TAB #1

BOARD COUNSEL SUGGESTED AMENDMENTS
FEBRUARY 2018

64B16-27.450 Prescription Department Managers.

(1) Designation as Prescription Department Manager.

(a) Initial Designation. Pursuant to Sections 465.018, 465.0197, and 465.022, F.S., a permit for a community or internet pharmacy may not be issued unless a licensed pharmacist is designated as the prescription department manager. In addition, pursuant to Rules 64B16-28.820, 64B16-28.830, and 64B16-28.901, applications for permits for a Special Parenteral and Enteral, Special Closed System, or Nuclear pharmacy require the supervising licensed pharmacist be designated as the prescription department manager. Initial d~~D~~esignation is accomplished as part of the application process using the appropriate application form ~~for a Community Pharmacy Permit, utilizing Form DH-MQA 1214, Community Pharmacy Permit Application and Information, incorporated in Rule 64B16-28.100, F.A.C., or as part of the application for an Internet Pharmacy Permit, utilizing Form DH-MQA 1220, Special Pharmacy Permit Application and Information,~~ incorporated in Rule 64B16-28.100, F.A.C.

(b) Change of prescription department manager. No later than ten (10) days after a change of designated prescription department manager for a community pharmacy, a Special Parenteral and Enteral pharmacy, a Special Closed System pharmacy, or a Nuclear pharmacy, or thirty (30) days for an internet pharmacy, both the pharmacy Permittee and the newly designated prescription department manager shall notify the Board of the change and the identity of the newly designated prescription department manager. Notification shall be accomplished by completing Form DOH/MQA/PH10, 02/18 ~~12/16~~, Change of Prescription Department Manager, which is hereby incorporated by reference and which can be obtained from http://www.flrules.org/Gateway/reference.asp?No=Ref-07929, the Board of Pharmacy, 4052 Bald Cypress Way, Bin #C04, Tallahassee, Florida 32399-3254, or the Board's website at http://floridaspharmacy.gov/Applications/app-change-perscription-dept-manager.pdf. In addition, an outgoing prescription department manager may choose to notify the Board they will no longer serve as prescription department manager using this form.

(c) Submission of Fingerprints. In addition to submission of Form DOH/MQA/PH10, the newly designated prescription department manager shall comply with the fingerprinting requirements of Sections 456.0135 and 465.022, F.S. This paragraph does not apply to persons fingerprinted pursuant to these statutes on or after July 1, 2013.

(2) Responsibilities of Prescription Department Managers. Prescription department managers are responsible for ensuring the pharmacy permittee's compliance with all statutes and rules governing the practice of the profession of pharmacy, including maintenance of all drug records and ensuring the security of the prescription department, and shall competently and diligently exercise their responsibilities as a prescription department manager.

(3) All community, ~~and~~ internet, Special Parenteral and Enteral, Special Closed System, and Nuclear pharmacy Permittees shall continuously maintain a designated prescription department manager at all times the pharmacy is open and in operation.

(4) Pursuant to Section 465.022(11)(b), F.S., a registered pharmacist may not serve as prescription department manager at more than one pharmacy location unless otherwise approved by the Board.

Rulemaking Authority 465.005, 465.0155, 465.022(1), (10) FS. Law Implemented 456.0135, 465.018(2), 465.0197(1), (3)(b), 465.022(2), (3), (10), (11) FS. History–New 3-9-17,_____.

TAB #2

BOARD COUNSEL SUGGESTED AMENDMENTS TO RULE
FEBRUARY 2018

64B16-28.501 Institutional Permit – Consultant Pharmacist of Record; Initial Designation; Change.

(1) Initial Designation as Consultant Pharmacist of Record. Pursuant to Sections 465.019 and 465.022, F.S., a permit for an Institutional pharmacy may not be issued unless a licensed pharmacist is designated as the consultant pharmacist of record. In addition, pursuant to Rule 64B16-28.901, an application for a Special Assisted Living Facility pharmacy permit require the supervising licensed pharmacist be designated as the consultant pharmacist of record. Initial designation is accomplished as part of the application process using the appropriate application form incorporated in Rule 64B16-28.100, F.A.C.

(2) Change of Consultant Pharmacist of Record.

(a) No later than ten (10) days after a change of designated consultant pharmacist for an Institutional or Special Assisted Living Facility pharmacy, both the pharmacy permittee and the newly designated consultant pharmacist of record shall notify the Board of the change and the identity of the newly designated consultant pharmacist. Notification shall be accomplished by completing Form DOH-MQA 1184 (02/18), Change of Consultant Pharmacist of Record, which is hereby incorporated by reference and which can be obtained from http://www.flrules.org/Gateway/reference.asp?No=Ref- or the Board's website at http://floridaspharmacy.gov/Applications/app-change-consultant-pharmacist.pdf.

(b) Submission of Fingerprints. In addition to submission of Form DOH-MQA 1184, the newly designated consultant pharmacist shall comply with the fingerprinting requirements of Sections 456.0135 and 465.022, F.S. This paragraph does not apply to persons fingerprinted pursuant to these statutes on or after July 1, 2013. ~~(1) Each facility holding a Class I, a Class II, or a Modified Class II Institutional permit shall designate a consultant pharmacist of record to ensure compliance with the laws and rules governing the permit. The Board office shall be notified in writing within ten (10) days of any change in the consultant pharmacist of record.~~

(3~~2~~) Drug Regimen Reviews. The consultant pharmacist of record for a Class I, Class II, or Modified Class II permit shall conduct Drug Regimen Reviews as required by Federal or State law, inspect the facility and prepare a written report to be filed at the permitted facility at least monthly. In addition, the consultant pharmacist of record must monitor the facility system for providing medication administration records and physician order sheets to ensure that the most current record of medications is available for the monthly drug regimen review. The consultant pharmacist of record may utilize additional consultant pharmacists to assist in this review and in the monthly facility inspection.

(4~~3~~) Remote Access. A consultant pharmacist licensed in Florida may remotely access a facility or pharmacy's electronic database from outside the facility or pharmacy to conduct any services additional or supplemental to regular drug regimen reviews, subject to the pharmacy or facility establishing policies and procedures to ensure the security and privacy of confidential patient records, including compliance with applicable Federal HIPAA regulations.

Rulemaking Authority 465.005, 465.0125, 465.022 FS. Law Implemented 465.0125, 465.019, 465.022, 465.0266 FS. History–New 7-18-94, Formerly 61F10-28.501, 59X-28.501, Amended 1-2-02, 12-30-07, 11-5-17,_____.

TAB #3

SUGGESTED RULE AMENDMENTS – JANUARY, 2018

64B16-28.100 Pharmacy Permits – Applications and Permitting.

This rule section establishes ~~addresses~~ the application and permitting requirements for pharmacies ~~of business establishments~~ regulated under Chapter 465, F.S. Any pharmacy establishment ~~that is required to have a permit~~ shall apply to the board for the appropriate permit on forms indicated in this rule. Applications and forms referenced in this section may be accessed or downloaded from the web at http://floridaspharmacy.gov/resources/ ~~http://www.doh.state.fl.us/mqa/pharmacy~~ or may be obtained by contacting ~~the Board~~ the Board of Pharmacy, at 4052 Bald Cypress Way, Bin #C04, Tallahassee, Florida 32399-3254, or (850)488-0595. Inquiries regarding the status of the application or license verification may be obtained at http://www.FLHealthsource.gov ~~com~~. The application must be accompanied by the appropriate fee as specified by Rule 64B16-26.1022, F.A.C. ~~with a $250 initial permit fee, payable to the Board.~~

(1) All Permits:

(a) Pursuant to Rule 64B16-28.113, F.A.C., a ~~A~~ permit is valid only for the name and physical location (address) to which it is issued. The name in which the permit is issued must be the name in which the company is doing business, i.e., the name that appears on purchase and sales invoices. *LDH – the remaining language reiterates existing rule 64B16-28.113, and therefore, appears to be redundant here and should be deleted.*

~~(a) A permit shall be issued only to a single entity at a single location. The service provided by the permit shall be consistent with the issued permit. A single location shall be defined as:~~

~~1. A contiguous area under the control of the permit holder. For purposes of this rule, a public thoroughfare will be considered to have not broken the area of contiguity; and,~~

~~2. An area not more than one half (1/2) mile from the central location of the permit~~

~~(b)~~ 1. The name in which a permit is issued may be changed upon notification to the board. To change the name in which a permit is issued the person or establishment must file with the board an original Form DH-MQA 1227 "Pharmacy Permit Name Change Form" Rev 02/18 ~~effective December 2010~~, which is incorporated by reference herein, and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref- or on the web at http://floridaspharmacy.gov/resources/ ~~http://www.doh.state.fl.us/mqa/pharmacy.~~

2. A pharmacy permit holder may request a change of practice location by completing the appropriate section(s) of the application form for the permit type.

3. Pharmacy permits are non-transferrable. However, pursuant to Rule 64B16-28.2021, transfers of ownership of business entities holding a permit may be allowed. A pharmacy permit holder shall notify the Board of changes of ownership of business entities by completing the appropriate section(s) of the application form for the permit type.

(b)~~(c)~~ Each applicant must comply with the fingerprinting requirements of section 465.022, F.S. *LDH – the remaining language should be deleted since it is outdated and incorrect.* ~~file with the board a legible set of fingerprint cards and a $48 fee for each person who submits an application meeting the requirements in Section 465.022(3), F.S. An applicant may register demographic information and purchase fingerprint cards (FD-258) at http://http://www.fldoh.sofn.net/. If an applicant chooses not to purchase a fingerprint card, the applicant must make sure the police or agency that rolls the fingerprints uses a FD-258 fingerprint card. A Non-Resident Pharmacy Registration applicant is not required to submit a legible set of fingerprints upon application.~~

(c)~~(d)~~ Pursuant to section 465.018(6), F.S., p~~P~~assing an on-site inspection is a prerequisite to issuance of a new permit, whether based on an initial application, change of ownership, or change of address. At the time of the on-site inspection, the board inspector will document the applicant's compliance with all applicable rules and statutes.

(d)~~(e)~~ Pursuant to section 465.022(4), F.S., e~~E~~ach applicant must attach to the application the applicant's written policies and procedures for preventing controlled substance dispensing based on fraudulent representations or invalid practitioner-patient relationships. The policy and procedure manual shall contain, at a minimum, the following:

1. Provisions to identify and guard against invalid practitioner-patient relationships.
2. Provisions to guard against filling fraudulent prescriptions for controlled substances.
3. Provisions to identify prescriptions that are communicated or transmitted legally.
4. Provisions to identify the characteristics of a forged or altered prescription.

LDH – this language came from the existing rule, paragraph (2)(c), which related only to community permits.

(2) A Community Pharmacy Permit, as authorized by Section 465.018, F.S., is required for every location where medicinal drugs are compounded, dispensed, stored, or sold or where prescriptions are filled or dispensed on an outpatient basis. Applicants for a

community pharmacy permit must complete an application for a permit using an original Form DH-MQA 1214, "Community Pharmacy Permit Application and Information," Rev 02/18 ~~effective August 2012~~ which is incorporated by reference herein and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref- .

~~(a)~~ Applicants for a Community Pharmacy Permit must~~:~~

~~1.~~ Comply with all permitting requirement found in subsection (1)~~,~~ of this rule~~;~~ and~~,~~

~~2.~~ Designate a prescription department manager as required by Section 465.018, F.S.

LDH – I don't think this remaining language is necessary; it is now part of 27.450 ~~(b) The permittee and the newly designated prescription department manager shall notify the board within 10 days of any change in the prescription department manager using an original Form DH-MQA PH10, "Prescription Department Manager Change," effective December 2010, which is incorporated by reference herein and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-02299.~~

LDH – as mentioned above, the following language has been moved to (1)(c), so as to apply to all permit applications as required by 465.022(4). ~~(c) The policy and procedure manual for Community Pharmacies shall contain the procedures implemented to minimize the dispensing of controlled substances based on fraudulent representations. The policy and procedural manual shall provide the following:~~

~~1. Provisions to identify and guard against invalid practitioner-patient relationships.~~

~~2. Provisions to guard against filling fraudulent prescriptions for controlled substances.~~

~~3. Provisions to identify prescriptions that are communicated or transmitted legally.~~

~~4. Provisions to identify the characteristics of a forged or altered prescription.~~

(3) An Institutional Pharmacy Permit,~~s~~ as authorized by Section 465.019, F.S., is required for any location in any health care institution where medicinal drugs are compounded, dispensed, stored or sold. Applicants for an Institutional Pharmacy permit must complete an application for a permit using an original Form DH-MQA 1215, "Institutional Pharmacy Permit Application and Information," Rev 02/18 ~~effective August 2012~~, which is incorporated by reference herein and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref- .

(a) Applicants for an Institutional Pharmacy Permit must~~:~~

~~1.~~ Comply with all permitting requirement found in subsection (1) of this rule~~;~~ and,

~~2.~~ Designate a consultant pharmacist of record as required by Section 465.019, F.S.

LDH – I moved this to Rule 64B16-27.501, Consultant Pharmacists. ~~(b) The Board shall be notified in writing within 10 days of any change in the consultant pharmacist of record using an original Form DH-MQA 1184, "Change of Consultant Pharmacist of Record," effective December 2010, which is incorporated by reference herein and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-02301.~~

(4) A Nuclear Pharmacy Permit, as authorized by Section 465.0193, F.S., is required for every location where radioactive drugs and chemicals within the classification of medicinal drugs are compounded, dispensed, stored, or sold. Applicants for a Nuclear Pharmacy permit must complete an application for a permit using an original Form DH-MQA 1218, "Nuclear Pharmacy Permit Application and Information," Rev 02/18 ~~effective August 2012~~, which is incorporated by reference herein and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref- .

(a) Applicants for a Nuclear Pharmacy Permit must:

1. Comply with all permitting requirement found in subsection (1), of this rule; and,

2. Designate a prescription department manager as required by Rule 64B16-28.901(1), F.A.C.. ~~Designate a nuclear pharmacist of record as required by Section 465.0193, F.S.~~

LDH – See my comment above – this language should be deleted as I think the PDM rule is sufficient. ~~(b) The permittee and the newly designated prescription department manager shall notify the board within 10 days of any change in the prescription department manager using an original Form DH-MQA PH10, "Prescription Department Manager Change," effective December 2010.~~

(5) Special Pharmacy Permits as authorized in Section 465.0196, F.S., are ~~is~~ required for any location where medicinal drugs are compounded, dispensed, stored, or sold and which are not a community pharmacy, institutional pharmacy, nuclear pharmacy or internet pharmacy. Applicants for a Special-Limited Community, Special – Parenteral and Enteral, Special – Closed System Pharmacy, Special – End Stage Renal Disease (ESRD), Special – Parenteral/Enteral Extended Scope, and Special – Assisted Living Facility (ALF) permits must complete an application for a permit using an original Form DH-MQA 1220, "Special Pharmacy Permit Application and Information," Rev 02/18 ~~effective August 2012~~, which is incorporated by reference herein and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref- .

(a) Applicants for a Special Pharmacy Permit must:

1. Comply with all permitting requirement found in subsection (1), of this rule; and,

2. Designate a prescription department manager or consultant pharmacist of record as required by Section 465.0196, F.S.

LDH – See my comment above – I think the PDM rule is sufficient (b) ~~The permittee and the newly designated prescription department manager shall notify the board within 10 days of any change in the prescription department manager using an original Form DH-MQA PH10, "Prescription Department Manager Change," effective December 2010.~~ .

LDH – see my comment above; this has been moved to Rule 64B16-27.501, Consultant Pharmacists ~~(c) The Board shall be notified in writing within 10 days of any change in the consultant pharmacist of record using an original Form DH-MQA 1184, "Change of Consultant Pharmacist of Record," effective December 2010.~~

~~(d)~~ The Board recognized the following types of Special Pharmacy permits:

1. Special Limited Community Permit is ~~may be obtained by~~ an Institutional Class II Pharmacy that dispenses medicinal drugs to employees, medical staff, emergency room patients, and other patients on continuation of a course of therapy.

2. Special Parenteral and Enteral Permit ~~is required to~~ provides parenteral (IV), enteral, and cytotoxic pharmacy services to outpatients. The applicant must be compliant with the Standard for Compounding Sterile Preparations found in Rule 64B16-27.797, F.A.C. Special – Parenteral and Enteral Pharmacy Permits may stand-alone or be used in conjunction with a Community Pharmacy or Special – Closed System Pharmacy Permit. The permittee must provide 24-hour telephone accessibility.

3. Special Closed System Pharmacy Permit is not open to the public and prescriptions are individually prepared for dispensing utilizing closed delivery systems, for ultimate consumers in health care institutions including nursing homes, jails, ALF's, Intermediate Care Facility/Mentally Retarded (ICF-MR's) or other custodial care facilities when defined by AHCA rules which the Board may approve. This permit may not provide medications to in-patients in a hospital. ***LDH – I don't know what this highlighted text means. I don't think the Board has any rule approving AHCA rules.***

4. Special Pharmacy – End Stage Renal Disease (ESRD) Permit is a type of special pharmacy which is limited in scope of pharmacy practice to the provision of dialysis products and supplies to persons with chronic kidney failure for self-administration at the person's home or specified address.

5. Special Pharmacy – Parenteral/Enteral Extended Scope Permit ~~is required for~~ pharmacies ~~to~~ compound patient specific parenteral/enteral preparations in conjunction with institutional pharmacy permits~~, provided requirements set forth herein are satisfied~~ ***LDH – I don't know what this highlighted text means. Do we mean the requirements of 28.860??***.

6. Special – Assisted Living Facility (ALF) Permit is an optional facility license for those Assisted Living Facilities providing a drug delivery system utilizing medicinal drugs provided in unit dose packaging.

(6) Internet Pharmacy Permit as authorized by Section 465.0197, F.S., is required for any location not otherwise licensed or issued a permit under this chapter, within or outside this state that uses the Internet to communicate with or obtain information from consumers and uses the information to fill or refill prescriptions or to dispense, distribute, or otherwise engage in the practice of pharmacy in this state. Applicants for an Internet Pharmacy permit must complete an application for a permit using an original Form DH-MQA 1220, "Special Pharmacy Permit Application and Information," Rev 02/18~~effective August 2012~~.

(a) Applicants for an Internet Pharmacy Permit must:

(a)~~1~~. Comply with all permitting requirement found in subsection (1), of this rule; and,

(b)~~2~~. Designate a prescription department manager or consultant pharmacist of record as required by Section 465.0197, F.S.

LDH – See my comment above – I think the PDM rule is sufficient. ~~(b) As set forth in Section 465.0197, F.S., the permittee shall notify the board within 30 days of any change of location, corporate officers, and the pharmacist serving as the prescription department manager using an original Form DH-MQA PH10, "Prescription Department Manager Change," effective December 2010.~~

(7) Special Sterile Compounding Permit: Except those pharmacies which already hold an active stand-alone Special Parenteral/Enteral or Special Parenteral/Enteral Extended Scope Compounding permit, any pharmacy engaged in sterile compounding must obtain a special sterile compounding permit by filing an application on form DH-MQA 1270, "Special Sterile Compounding Permit Application and Information," Rev 02/18~~effective May 2013~~, which is incorporated by reference herein and is available at http://www.flrules.org/Gateway/reference.asp?No=Ref-___.

LDH – appears unnecessary at this point, 4 years later. ~~(a) All applicants that hold an active pharmacy permit that are currently engaged in sterile compounding have 180 days from the effective date of this amendment (eff. 9/23/13) to obtain a Special Sterile Compounding Permit. All pharmacies, which obtain the permit within the 180 days, on or before March 21, 2014, are exempt from paying an additional application or license fee.~~

~~(b)~~ Applicants for a Special Sterile Compounding Permit must:

(a)~~1.~~ Comply with all permitting requirements in subsection (1), of this rule,

(b)~~2.~~ Designate a prescription department manager or consultant pharmacist of record.

LDH – See my comment above – I think the PDM and CPOR rules are sufficient. ~~(c) The permittee and the newly designated prescription department manager of record or consultant pharmacist of record shall notify the board within 10 days of any change in the prescription department manager or consultant pharmacists of record on FORM DH-MQA-PH10, "Prescription Department Manager Change," effective December 2010 or FORM DH-MQA 1184, "Change of Consultant Pharmacist of Record."~~

Rulemaking Authority 465.005, 465.022 FS. Law Implemented 456.013, 456.025(3), 456.0635, 465.018, 465.019, 465.0193, 465.0196, 465.0197, 465.022 FS. History–New 2-21-13, Amended 9-23-13, 5-31-17.

TAB #4

DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF PHARMACY
4052 BALD CYPRESS WAY, BIN #C-04
TALLAHASSEE, FLORIDA 32399-3254
(850) 245-4292

COMMUNITY PHARMACY PERMIT APPLICATION AND INFORMATION

January 2018

Dear Florida Pharmacy Permit Applicant,

Thank you for applying for a pharmacy permit in the State of Florida. The information in this packet has been designed to provide the essential information required to process your application in a timely manner. Your assistance in providing all required information will enable the Florida Board of Pharmacy (the Board) staff to process your application as soon as possible. You are encouraged to apply as early as possible to avoid processing delays caused by large volumes of applicants.

Florida Statutes require a completed application and fees before your application can be reviewed. Please read these instructions carefully and fully before submitting your application. You should keep a copy of the completed application and all other materials sent to the Board office for your records. When you mail the completed application and fees, use the address noted in the instructions and on the application form.

When your application arrives, your fees will be deposited and verified before the staff review can begin. You will receive a letter acknowledging receipt of your application. The staff will notify you within 30 days if any materials are incomplete.

If you need to communicate with the Board staff, you are encouraged to email the Board staff at info@floridaspharmacy.gov, or you may at call us at (850) 245-4292. Phone calls are returned within 24 hours and emails are responded to within 48 hours during normal business hours. Our staff is committed to providing prompt and reliable information to our customers. Many procedures have been streamlined to expedite the processing of applications; we certainly welcome your comments on how our services may be improved.

Sincerely,

The Board of Pharmacy

COMMUNITY PHARMACY PERMIT APPLICATION INFORMATION

Whether opening a new establishment, changing locations, or changing owners, a pharmacy permit is required prior to operating in the State of Florida. The permit application must be completed and returned to the Florida Board of Pharmacy with the required fee of $255.00. The application MUST have the original signatures of the owner or officer of the establishment and the Prescription Department Manager (PDM). If compounding sterile preparations, submit an additional application on Form DH-MQA 1270, "Special Sterile Compounding Permit" and pay the additional permitting fee.

A Community Pharmacy provides outpatient pharmacy services, and is open for a minimum of 20 hours per week unless reduced hours have been approved by the Board. Section 465.018, Florida Statutes, requires a permit holder to designate a pharmacist licensed in the State of Florida as the manager of the prescription department. The Prescription Department Manager (PDM) is responsible for ensuring the pharmacy permittee's compliance with all statutes and rules governing the practice of the profession of pharmacy, including maintenance of all drug records and ensuring the security of the prescription department, and shall competently and diligently exercise their responsibilities as a prescription department manager. Please see Rule 64B16-27.450, F.A.C., for more information.

Section 465.022(4), Florida Statutes, also provides that an application for a pharmacy permit must include the applicant's written policies and procedures for preventing controlled substance dispensing based on fraudulent representations or invalid practitioner-patient relationships. Pursuant to Rule 64B16-28.100(1)(e), F.A.C., The policy and procedure manual for a Community Pharmacy shall contain the procedures implemented to minimize the dispensing of controlled substances based on fraudulent representations as follows:

1. Provisions to identify and guard against invalid practitioner-patient relationships.
2. Provisions to guard against filling fraudulent prescriptions for controlled substances.
3. Provisions to identify prescriptions that are communicated or transmitted legally.
4. Provisions to identify the characteristics of a forged or altered prescription.

Application Processing

Please read all application instructions before completing your application.

1) Please mail the application and the $255.00 application fee (cashier's check or money order made payable to the FLORIDA DEPARTMENT OF HEALTH) to the following address:

Application & Fees:
Department of Health
Board of Pharmacy
P.O. Box 6320
Tallahassee, Florida 32314-6320

Express Mail ONLY
Department of Health
Board of Pharmacy
4052 Bald Cypress Way, Bin C-04
Tallahassee, FL 32399-3254

Within 30 days of receipt of your application and fees, the Board office will notify you of the receipt of your application, any required documents, and your status. If the application is complete, you will be notified that an inspector will contact you to setup an inspection appointment. If your application is incomplete, you will be notified in writing of what is required to make your application complete.

2) Submit fingerprint results.

Failure to submit fingerprints will delay your application. All owners, officers, and PDMs are required to submit a set of fingerprints unless the corporation is exempt under the Section 465.022, Florida Statutes, for corporations having more than $100 million of business taxable assets in this state. These corporations are only required to have the PDM to submit fingerprints. **Note: If your officer, owner, or PDM has already been fingerprinted at the time you are completing this Community Pharmacy permit application, please ensure to provide the Transaction Control Number (TCN) with the requested information in the application.**

Applicants may use any Livescan vendor that has been approved by the Florida Department of Law Enforcement to submit their fingerprints to the department. Please ensure that the Originating Agency Identification (ORI) number is provided to the vendor when you submit your fingerprints. If you do not provide an ORI number or if you provide an incorrect ORI number to the vendor, the Board of Pharmacy will not receive your fingerprint results. The applicant is fully responsible for selecting the vendor and ensuring submission of the prints to the Department.

How do I find a Livescan vendor in order to submit my fingerprints to the Department?
The Department of Health accepts electronic fingerprinting service offered by Livescan device vendors that are approved by the Florida Department of Law Enforcement and listed at their site. You can view the vendor options and contact information at:

http://www.floridahealth.gov/licensing-and-regulation/background-screening/livescan-service-providers.html

What information must I provide to the Livescan vendor I choose?

- If you are an applicant seeking a license for any profession regulated by the Department of Health, which requires a criminal background search as a condition of licensure, you must provide accurate demographic information at the time your fingerprints are taken, ***including your Social Security number***. The Department will not be able to process a submission that does not include your Social Security number.
- You must provide the correct ORI number.

Where do I get the ORI number to submit to the vendor?

- The ORI number for the pharmacy profession is **EDOH4680Z.**

Attestation for Business Taxable Assets

- If the applicant has more than $100 million dollars of business taxable assets in this state, please submit a formal opinion letter from a Certified Public Accountant duly licensed in the state of your principal place of business affirming the corporation has more than $100 million of business taxable assets in this state for the previous tax year. In lieu of submitting a formal opinion letter from a Certified Public Accountant, the applicant may submit a copy of its Florida Corporate Income/Franchise and Emergency Excise Tax Return (Form F-1120, Effective 01/09).

3) Privacy Statement and Attestation

In order for the Board of Pharmacy Office to receive your Livescan electronic fingerprinting results, you must affirm that you have been provided with and read the attached statement from the Florida Department of Law Enforcement regarding the sharing, retention, and right to challenge incorrect criminal history records, and the "Privacy Statement" document from the Federal Bureau of Investigation. The appropriate form(s) to provide this affirmation are included within Items #1 and #2 of the application.

Licensure Process

Once the application is deemed complete, the Board staff authorizes an inspection. Upon completion of the inspection, the inspector notifies the Board office as to whether the inspection was satisfactory or unsatisfactory. If the inspection is satisfactory, a permit number is issued within 7-10 days. You will receive the actual copy of your license within 7 days. **Please wait 7-14 days from your satisfactory inspection before checking on the status of your permit with the Board office**.

You may look up your license number on our website at http://www.flhealthsource.com/ under "Verify a License."

The Board recognizes that a delay may exist between the time a pharmacy receives a Florida pharmacy permit and commences to operate. Accordingly, upon receipt of Community Pharmacy permit, a pharmacy may delay commencement of operations in compliance with the requirements provided in Rule 64B16-28.1081, F.A.C.

Drug Enforcement Administration (DEA)

Please note that the DEA will not issue a registration until the Florida Board of Pharmacy has issued a pharmacy permit. More information is available by visiting the DEA website at http://www.DEAdiversion.usdoj.gov, or by contacting them at (800)667-9752.

IMPORTANT NOTICE: Pursuant to Section 465.022(5), F.S., the Department or Board shall deny an application for a pharmacy permit if the applicant or an affiliated person, partner, officer, director, or prescription department manager or consultant pharmacist of record of the applicant:

(a) Has obtained a permit by misrepresentation or fraud.

(b) Has attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation.

(c) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy.

(d) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud.

(e) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, since July 1, 2009.

(f) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009.

(g) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period.

(h) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5-year period and the termination occurred at least 20 years before the date of the application.

(i) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

(j) Has dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466.

For felonies in which the defendant entered a plea of guilty or nolo contendere in an agreement with the court to enter a pretrial intervention or drug diversion program, the department shall deny the application if upon final resolution of the case the licensee has failed to successfully complete the program.

<u>If applicable to you, please provide the documentation to the Florida Board of Pharmacy.</u>

PHARMACY PERMIT APPLICATION CHECKLIST

Keep a copy of the completed application for your records.

It is recommended that you use the following checklist to help ensure that your application is complete. Failure to attach any required document, or to have required documentation sent to the Board, will result in an incomplete application. Final approval for inspection cannot be granted until the application is complete.

COMMUNITY PHARMACY PERMIT

_____All Application Questions Answered?

_____$255.00 Fee Attached (Permit fee includes $250 application fee and $5.00 unlicensed activity fee)

_____Articles of Incorporation paperwork from the Secretary of State provided?

_____PDM Designation and Privacy Statement Acknowledgement provided (Application Item #1)?

_____Affiliate/Owner Privacy Statement Acknowledgement provided for each affiliate/owner (Application Item #2)?

_____Applicant/Affiliate/Owner supplemental documents provided for explaining any previous ownership, disciplinary actions, voluntary relinquishments and/or criminal activity?

_____Applicant/Affiliate/Owner pharmacy permit questions answered and supplemental documents provided?

_____Policies and Procedures for preventing controlled substance dispensing based on fraudulent representations or invalid practitioner-patient relationships submitted?

FLORIDA BOARD OF PHARMACY
P.O. Box 6320
Tallahassee, FL 32314-6320
850-245-4292
http://www.floridaspharmacy.gov

COMMUNITY PHARMACY PERMIT

APPLICATION

Application Type – Please choose one of the following:

___New Establishment ($255.00 fee)
Complete: Section A only, along with Items #1 and 2.

___Change of Ownership ($255.00 fee)
Complete: Sections A and C only, along with Items #1 and 2.

___ Change of Location ($100.00 fee)
Complete: Sections A and B only.

___ Stock Transfer (no fee)
Complete: Section A, pages 2-3 and Section D only.

SECTION A. Please complete for all Application Types

Please list your Federal Employer Identification Number:

1. Corporate Name	**Telephone Number**

2. Doing Business As (d/b/a)	**E-Mail Address**** (see note below)

3. Mailing Address		
City	**State**	**Zip**

4. Physical Address		
City	**State**	**Zip**

5. Prescription Department Manager (PDM) Information

Name	**License Number**

Email Address ** (see note below)	**Telephone Number**

6. Contact Person	**Title**

Email Address ** (see note below)	**Telephone Number**

NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

7. Operating Hours

Is the pharmacy open at least 20 hours per week? Yes_____ No_____

8. Ownership Information

a. Type of Ownership: _____Individual _____Corporation _____Partnership

NOTE: If the applicant is a corporation or limited partnership you must include with your application a copy of the Articles of Incorporation on file with the Florida Secretary of State's office.

b. Are the applicants, officers, directors, shareholders, members and partners over the age of 18?

Yes _____ No _____

c. Does the corporation have more than $100 million of business taxable assets in this state? *If yes, provide attestation from Certified Public Accountant for previous tax year or Florida Corporate Income /Franchise and Emergency Excise Tax Return (F-1120).*

Yes _____ No _____

d. List all the owners and officers of the corporation. Each person listed below having an ownership interest of 5% or greater and any person who, directly or indirectly, manages, oversees, or controls the operation of the applicant including officers and members of the board of directors must submit a set of fingerprints and fees unless you answered yes to 8c. If 8c is "Yes", please list the owners below and only submit fingerprints for the Prescription Department Manager. If 8c is "Yes" and the prints are on file with DOH or AHCA and available to the Board of Pharmacy, the requirement to submit the prints for this person is met. Also, if the % of Ownership column does not add to 100%, please provide an explanation. *Attach a separate sheet if necessary.*

Owner/Officer-Title	Date of Birth	Mailing Address, City, State, Zip Code	% of Ownership
	/ /		%
	/ /		%
	/ /		%
	/ /		%
	/ /		%

9. Has anyone listed in 8.d had an ownership interest of 5% or more in a pharmacy or any other business permit which was disciplined, suspended, revoked, or closed involuntarily within the past 5 years? *If yes, please provide a signed affidavit disclosing the reason the entity was closed.*

Yes _____ No _____ .

9a. Has anyone listed in 8.d had an ownership interest of 5% or more in a pharmacy or any other business permit which was voluntarily relinquished or closed voluntarily within the past 5 years? *If yes, please provide a signed affidavit disclosing the reason the entity was closed.*

Yes _____ No _____ .

Pursuant to Section 465.022(5), Florida Statutes, the following questions are being asked. If you answer "Yes" to any of the following questions, explain <u>on a separate sheet</u> providing accurate details and submit copies of supporting documentation.
10. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant obtained a permit by misrepresentation or fraud?
Yes _____ No_____
11. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation?
Yes _____ No _____
12. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy?
Yes _____ No_____
13. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud?
Yes_____ No_____
14. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, since July 1, 2009?
Yes _____ No_____
15. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009?
Yes _____ No _____
16. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period?
Yes _____ No _____
17. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5-year period and the termination occurred at least 20 years before the date of the application?
Yes _____ No _____

18. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health Human Services Office of Inspector General's List of Excluded Individuals and Entities? *(If yes, please submit proof.)*

Yes _____ No _____

19. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466?

Yes_____ No ___

20. Are you currently registered or permitted in any other states? *(If yes, provide the state, permit type and permit number for each permit. Attach a separate sheet if necessary.)*

Yes _____ No _____

State	Permit Type	Permit Number

21. Has the applicant, affiliated person, partner, officer, directors, or Prescription Department Manager ever owned a pharmacy? *(If yes, provide the name of the pharmacy, the state where the pharmacy is located and the status of the pharmacy. Attach a separate sheet if necessary.)*

Yes _____ No _____

Individual's Name	Pharmacy Name	State	Status

22. Has any disciplinary action ever been taken against any license, permit or registration issued to the applicant, affiliated person, partner, officer, director, or prescription department manager?

Yes _____ No _____

23. Has the applicant, affiliated person, partner, officer, or director ever been convicted of a felony or misdemeanor, excluding minor traffic convictions? You must include all misdemeanors and felonies, even if adjudication was withheld by the court, so that you would not have a record of conviction.

Yes _____ No _____

24. Does the applicant, affiliated person, partner, officer, director have any outstanding fines, liens or overpayments assessed by a final order of the department? If yes please answer 24a.

Yes _____ No _____

24a. Does the applicant, affiliated person, partner, officer, director have a repayment plan approved by the department?

Yes _____ No _____

25. Will the Pharmacy Dispense Schedule II and/or III Controlled Substances?

Yes _____ No _____

26. Will the Pharmacy act as a Central Fill Pharmacy?

Yes _____ No_____

SECTION B. Please complete for Change of Location only.

1. Current Practice Location Address

City	**State**	**Zip**

E-Mail Address** (see note below)	**Telephone Number**

2. New Practice Location Address

City	**State**	**Zip**

E-Mail Address** (see note below)	**Telephone Number**

Please provide your existing Pharmacy Permit Number:

Please provide your existing federal DEA Number:

NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

SECTION C. Please complete for Change of Ownership only.

1. Are you changing physical locations with this change of ownership?

Yes _____ No _____ *NOTE: If yes, please complete **Section B** above.*

2. Please provide date when business transaction for the change of ownership will be completed?

Date: _____

3. Do you have a signed letter from both the buyer and seller which indicates dates that pharmacy permit license should be transferred? *NOTE: A copy of the signed letter should be provided with your application.*

Yes _____ No _____

SECTION D. Please complete for Stock Transfer of Ownership only.

1. Please provide the date when the transfer of ownership interest took place?

Date: _____

2. Did your company's FEIN change as a result of the transfer of ownership interest referenced in Section D, Question 1 above?

Yes _____ No _____ *NOTE: If yes, please complete **Section C** above and include necessary fee.*

ALL QUESTIONS MUST BE ANSWERED OR YOUR APPLICATION WILL BE RETURNED

****

Section 456.013(1), F.S., requires that applicants supplement their applications as needed to reflect any material change in any circumstances or conditions stated in the application, which takes place between the initial filing of the application and the final grant or denial of the license, which might affect the decision of the department.

I swear or affirm that the statements contained in this application are true, complete, and correct and I agree that said statements shall form the basis of my application and I do authorize the Florida Board of Pharmacy to make any investigations that they deem appropriate and to secure any additional information concerning me, and I further authorize them to furnish any information they may have or have in the future concerning me to any person, corporation, institution, association, Board, or any municipal, county, state, or federal governmental agencies or units, and I understand according to the Florida Board of Pharmacy Statutes that a Pharmacy Permit may be revoked or suspended for presenting any false, fraudulent, or forged statement, certificate, diploma, or other item, in connection with an application for a license or permit, as set forth in Section 465.015(2)(a), F.S.

Under penalty of perjury I have read the foregoing document and that the facts stated in it are true. I recognize that providing false information may result in disciplinary action against my license or criminal penalties.

SIGNATURE _____ DATE_____
(Owner or officer of establishment)

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.
Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice, Federal Bureau of Investigation,
Criminal Justice Information Services Division

Privacy Statement

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as my be relevant to the activity for which this application is being submitted, the FBI(may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law , treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Electronic Fingerprinting

Take this form with you to the Live Scan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at: http://www.doh.state.fl.us/mqa/background.html;
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the livescan service provider the Board office will not receive your background screening results;
- You must provide accurate demographic information to the livescan service provider at the time your fingerprints are taken, ***including your Social Security number (SSN)***;
- The ORI number for the Board of Pharmacy is **EDOH4680Z.**
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name:_____ SSN#: _____ - ____ - _____

Aliases:_____

Address:_____Apt. Number:_____

City:_____ State: _____Zip Code: _____

Date of Birth: _____/_____/_____ Place of Birth: _____
(MM/DD/YYYY)

Weight: _____ Height: _____ Eye Color:_____ Hair Color: _____

Race: _____
(W-White/Latino(a); B-Black; A-Asian;
NA-Native American; U-Unknown)

Sex: _____
(M=Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#):_____
(*This will be provided to you by the Live Scan Service provider*.)

Keep this form for your records.

Item #1- PDM Designation and Privacy Statement Acknowledgement

File #: (if known):
License #: (if applicable):

To: **Florida Board of Pharmacy**
Post Office Box 6320
Tallahassee, FL 32314-6320
(850) 245-4292- phone
(850) 413-6982 - fax
MQAPharmPDMAffiliate@flhealth.gov

Section A. Prescription Department Manager (PDM) Designation

Applicant/Pharmacy Name:		
Applicant/Pharmacy Mailing Address:		
City	**State**	**Zip**
Incoming PDM Name:		**License#:**
		PS
Date Beginning as PDM:	**Incoming PDM Signature**	
PDM Transaction Control Number (TCN) – related to Livescan Fingerprints:		
****OPTIONAL: Only provide following information if there is an Outgoing PDM at current pharmacy****		
Outgoing PDM Name:		**License#:**
		PS
Date Ending as PDM:	**Outgoing PDM Signature**	

Section B. Incoming PDM Privacy Statement Acknowledgement

Note: Acknowledgment should be completed by same person listed in Section A above as Incoming PDM.

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

Date:	**Incoming PDM Signature**

Item #2- Affiliate/Owner Privacy Statement Acknowledgement

To be completed by EACH Affiliate/Owner listed in the application.

To: **Florida Board of Pharmacy, Post Office Box 6320, Tallahassee, FL 32314-6320**
(850) 245-4292- phone * (850) 413-6982 – fax * MQAPharmPDMAffiliate@flhealth.gov

From:

Affiliate / Owner Name:		**File # (required):**
Applicant Name:		
Affiliate/Owner Mailing Address:		
City	**State**	**Zip**
Affiliate/Owner E-Mail ** (see note below)	**Affiliate/Owner Telephone Number**	
Affiliate/Owner Transaction Control Number (TCN) – related to Livescan Fingerprints:		
NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.		

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

_____ _____

Affiliate/Owner Signature (Required) **Date (of signature)**

DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF PHARMACY
4052 BALD CYPRESS WAY, BIN #C-04
TALLAHASSEE, FLORIDA 32399-3254
(850) 245-4292

INSTITUTIONAL PHARMACY PERMIT APPLICATION AND INFORMATION

January 2018

Dear Florida Pharmacy Permit Applicant,

Thank you for applying for a pharmacy permit in the State of Florida. The information in this packet has been designed to provide the essential information required to process your application in a timely manner. Your assistance in providing all required information will enable the Florida Board of Pharmacy (the board) staff to process your application as soon as possible. You are encouraged to apply as early as possible, to avoid delays due to a large volume of applicants.

Florida Statutes require a completed application and fees before your application can be reviewed. Please read these instructions carefully and fully before submitting the application. You should keep a copy of the completed application and all other materials sent to the board office for your records. When you mail the completed application and fees, use the address noted in the instructions and on the application form.

When your application arrives, your fees will be deposited and verified before the staff review can begin. You will receive a letter acknowledging receipt of your application. The staff will notify you within 30 days if any materials are incomplete.

If you need to communicate with the board staff, you are encouraged to email the board staff at info@floridaspharmacy.gov, or you may at call us at (850) 245-4292. Phone calls are returned within 24 hours and emails are responded to within 48 hours during normal business hours. Our staff is committed to providing prompt and reliable information to our customers. Many procedures have been streamlined to expedite the processing of applications; we certainly welcome your comments on how our services may be improved.

Sincerely,

The Board of Pharmacy

INSTITUTIONAL PHARMACY PERMIT APPLICATION INFORMATION

Whether opening a new establishment, changing locations, or changing owners, a pharmacy permit is required prior to operating in the State of Florida. The permit application must be completed and returned to the Florida Board of Pharmacy with the required fee of $255.00. The application MUST have the original signatures of the owner or officer of the establishment and the Consultant Pharmacist of Record (COR). If compounding sterile preparations, submit an additional application on Form DH-MQA 1270, "Special Sterile Compounding Permit" and pay the additional permitting fee.

There are three types of Institutional Pharmacy Permit applicants. Please read the description below. Check which permit type you are applying for on the application.

1. **Institutional Class I Pharmacy** – An Institutional Class I pharmacy is an institutional pharmacy in which all medicinal drugs are administered from individual prescription containers to the individual patient and in which medicinal drugs are not dispensed on the premises. No medicinal drugs may be dispensed in a Class I Institutional pharmacy. A Special- Closed System Pharmacy Permit, Special Parenteral and Enteral Pharmacy Permit, or Community Pharmacy Permit provide the individual patient prescriptions

2. **Institutional Class II Pharmacy Permit** – An Institutional Class II pharmacy is an institutional pharmacy that employs the services of a registered pharmacist or pharmacists who, in practicing institutional pharmacy, provide dispensing and consulting services on the premises to patients of that institution, for use on the premises of that institution. An Institutional Class II pharmacy is required be open sufficient hours to meet the needs of the hospital facility.

An Institutional Class II Pharmacy may elect to participate in the Cancer Drug Donation Program. If you are applying for this permit and would like to participate, please answer "yes" on question 20 of the application and attach a Notice of Participation to your application. For more information about the Cancer Drug Donation Program, and for a copy of the Notice of Participation, please visit the program's website at www.doh.state.fl.us/mqa/ddc/cancer.

3. **Modified Institutional Class II Pharmacy Permits -** Modified Institutional Class II pharmacies are those institutional pharmacies in short-term, primary care treatment centers that meet all the requirements for a Class II permit, except space and equipment requirements. Modified Class II Institutional pharmacies are designated as Type "A", Type "B" and Type "C" according to the type of specialized pharmaceutical delivery system utilized. Please review Rule 64B16-28.702, Florida Administrative Code for specific requirements.

Section 465.022(4), Florida Statutes, also provides that an application for a pharmacy permit must include the applicant's written policies and procedures for preventing controlled substance dispensing based on fraudulent representations or invalid practitioner-patient relationships. The policy and procedure manual shall contain the procedures implemented to minimize the dispensing of controlled substances based on fraudulent representations as follows:

1. Provisions to identify and guard against invalid practitioner-patient relationships.
2. Provisions to guard against filling fraudulent prescriptions for controlled substances.
3. Provisions to identify prescriptions that are communicated or transmitted legally.
4. Provisions to identify the characteristics of a forged or altered prescription.

Application Processing

Please read all application instructions before completing your application.

1) Mail Application.

Please mail the application and the $255.00 application fee (cashier's check or money order made payable to the FLORIDA DEPARTMENT OF HEALTH) to the following address:

Application & Fees:
Department of Health
Board of Pharmacy
P.O. Box 6320
Tallahassee, Florida 32314-6320

Express Mail ONLY
Department of Health
Board of Pharmacy
4052 Bald Cypress Way, Bin C-04
Tallahassee, FL 32399-3254

Within 30 days of receipt of your application and fees, the Board office will notify you of the receipt of your application, any required documents, and your status. If the application is complete, you will be notified that an inspector will contact you to setup an inspection appointment. If your application is incomplete, you will be notified in writing of what is required to make your application complete.

2) Submit fingerprint results.

Failure to submit fingerprints will delay your application. All owners, officers, and PDMs are required to submit a set of fingerprints unless the corporation is exempt under the Section 465.022, Florida Statutes, for corporations having more than $100 million of business taxable assets in this state. These corporations are only required to have the PDM to submit fingerprints. **Note: If your officer, owner, or Consultant Pharmacist of Record (COR) has already been fingerprinted at the time you are completing this Community Pharmacy permit application, please ensure to provide the Transaction Control Number (TCN) with the requested information in the application.**

Applicants may use any Livescan vendor that has been approved by the Florida Department of Law Enforcement to submit their fingerprints to the department. Please ensure that the Originating Agency Identification (ORI) number is provided to the vendor when you submit your fingerprints. If you do not provide an ORI number or if you provide an incorrect ORI number to the vendor, the Board of Pharmacy will not receive your fingerprint results. The applicant is fully responsible for selecting the vendor and ensuring submission of the prints to the Department.

How do I find a Livescan vendor in order to submit my fingerprints to the Department?
The Department of Health accepts electronic fingerprinting service offered by Livescan device vendors that are approved by the Florida Department of Law Enforcement and listed at their site. You can view the vendor options and contact information at:

http://www.floridahealth.gov/licensing-and-regulation/background-screening/livescan-service-providers.html

What information must I provide to the Livescan vendor I choose?

- If you are an applicant seeking a license for any profession regulated by the Department of Health, which requires a criminal background search as a condition of licensure, you must provide accurate demographic information at the time your fingerprints are taken, ***including your Social Security number***. The Department will not be able to process a submission that does not include your Social Security number.
- You must provide the correct ORI number.

Where do I get the ORI number to submit to the vendor?
The ORI number for the pharmacy profession is **EDOH4680Z**.

Attestation for Business Taxable Assets
If the applicant has more than $100 million dollars of business taxable assets in this state, please submit a formal opinion letter from a Certified Public Accountant duly licensed in the state of your principal place of business affirming the corporation has more than $100 million of business taxable assets in this state for the previous tax year. In lieu of submitting a formal opinion letter from a Certified Public Accountant, the applicant may submit its Florida Corporate Income/Franchise and Emergency Excise Tax Return (Form F-1120, Effective 01/09).

3) Privacy Statement and Attestation

In order for the Board of Pharmacy Office to receive your Livescan electronic fingerprinting results, you must affirm that you have been provided with and read the attached statement from the Florida Department of Law Enforcement regarding the sharing, retention, and right to challenge incorrect criminal history records, and the "Privacy Statement" document from the Federal Bureau of Investigation. The appropriate form(s) to provide this affirmation are included within Items #1 and #2 of the application.

Licensure Process

Once the application is deemed complete, the board staff authorizes an inspection. Upon completion of the inspection, the inspector notifies the board office as to whether the inspection was satisfactory or unsatisfactory. If the inspection is satisfactory, a permit number is issued within 10 days. **Please wait 7 - 14 days from your satisfactory inspection before checking on the status of your permit**.

You may look up your license number on our website at http://www.flhealthsource.com/ under "Verify a License."

Drug Enforcement Administration (DEA)

Please note that the DEA will not issue a registration until the Florida Board of Pharmacy has issued a pharmacy permit. More information is available by visiting the DEA website at http://www.DEAdiversion.usdoj.gov, or by contacting them at (800)667-9752.

IMPORTANT NOTICE: Pursuant to Section 465.022(5), F.S., the Department or Board shall deny an application for a pharmacy permit if the applicant or an affiliated person, partner, officer, director, or prescription department manager or consultant pharmacist of record of the applicant:

(a) Has obtained a permit by misrepresentation or fraud.

(b) Has attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation.

(c) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy.

(d) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud.

(e) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, since July 1, 2009.

(f) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009.

(g) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period.

(h) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5-year period and the termination occurred at least 20 years before the date of the application.

(i) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

(j) Has dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466.

For felonies in which the defendant entered a plea of guilty or nolo contendere in an agreement with the court to enter a pretrial intervention or drug diversion program, the department shall deny the application if upon final resolution of the case the licensee has failed to successfully complete the program.

<u>If applicable to you, please provide the documentation to the Florida Board of Pharmacy.</u>

PHARMACY PERMIT APPLICATION CHECKLIST

Keep a copy of the completed application for your records.

It is recommended that you use the following checklist to help ensure that your application is complete. Failure to attach any required document, or to have required documentation sent to the Board, will result in an incomplete application. Final approval for inspection cannot be granted until the application is complete.

INSTITUTIONAL PHARMACY PERMIT

_____All Application Questions Answered?

_____$255.00 Fee Attached (Permit fee includes $250 application fee and $5.00 unlicensed activity fee)

_____Articles of Incorporation paperwork from the Secretary of State provided?

_____COR Designation and Privacy Statement Acknowledgement provided (Application Item #1)?

_____Affiliate/Owner Privacy Statement Acknowledgement provided for each affiliate/owner (Application Item #2)?

_____Answers to Policy and Procedure Questions provided for **Institutional Pharmacy** applicants (Application Item #3)?

_____Answers to Policy and Procedure Questions provided for **Modified Class II Institutional Pharmacy** applicants (Application Item #4)?

_____Applicant/Affiliate/Owner supplemental documents provided for explaining any previous ownership, disciplinary actions, voluntary relinquishments and/or criminal activity?

_____Applicant/Affiliate/Owner pharmacy permit questions answered and supplemental documents provided?

_____Policies and Procedures for preventing controlled substance dispensing based on fraudulent representations or invalid practitioner-patient relationships submitted?

FLORIDA BOARD OF PHARMACY
P.O. Box 6320
Tallahassee, FL 32314-6320
850-245-4292
http://www.floridaspharmacy.gov

INSTITUTIONAL PHARMACY PERMIT

APPLICATION

Application Type – Please choose one of the following:

___New Establishment ($255.00 fee)
Complete: Section A only, along with Items #1 and 2.

___Change of Ownership ($255.00 fee)
Complete: Sections A and C only, along with Items #1 and 2.

___ Change of Location ($100.00 fee)
Complete: Sections A and B only.

___ Stock Transfer (no fee)
Complete: Section A, pages 2-3 and Section D only.

Pharmacy Permit Type – Please choose only one of the following:

____Institutional Class I

____Institutional Class II
Complete: Item #3 only,

Modified Institutional Class II A ___Class II B____ Class II C___
Complete: Item #4 only,

SECTION A. Please complete for all Application Types

Please list your Federal Employer Identification Number:

1. Corporate Name	**Telephone Number**

2. Doing Business As (d/b/a)	**E-Mail Address**** (see note below)

3. Mailing Address

City	**State**	**Zip**

4. Physical Address

City	**State**	**Zip**

5. Consultant Pharmacist of Record (COR) Information

Name	**License Number**

Email Address ** (see note below)	**Telephone Number**

6. Contact Person	**Title**

Email Address ** (see note below)	**Telephone Number**

NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

7. Ownership Information

a Type of Ownership: _____Individual _____Corporation _____Partnership

NOTE: If the applicant is a corporation or limited partnership you must include with your application a copy of the Articles of Incorporation on file with the Florida Secretary of State's office.

b. Are the applicants, officers, directors, shareholders, members and partners over the age of 18?

Yes _____ No_____

c. Does the corporation have more than $100 million of business taxable assets in this state? *If yes, provide attestation from Certified Public Accountant for previous tax year or Florida Corporate Income /Franchise and Emergency Excise Tax Return (F-1120).*

Yes _____ No_____

d. List all the owners and officers of the corporation. Each person listed below having an ownership interest of 5% or greater and any person who, directly or indirectly, manages, oversees, or controls the operation of the applicant including officers and members of the board of directors must submit a set of fingerprints and fees unless you answered yes to 8c. If 8c is "Yes", please list the owners below and only submit fingerprints for the Consultant Pharmacist of Record. If 8c is "Yes" and the prints are on file with DOH or AHCA and available to the Board of Pharmacy, the requirement to submit the prints for this person is met. Also, if the % of Ownership column does not add to 100%, please provide an explanation. *Attach a separate sheet if necessary.*

Owner/Officer-Title	Date of Birth	Mailing Address, City, State, Zip Code	% of Ownership
	/ /		%
	/ /		%
	/ /		%
	/ /		%
	/ /		%

8. Has anyone listed in 7.d has an ownership interest of 5% or more in a pharmacy or any other business permit which was disciplined, suspended, revoked, or closed involuntarily within the past 5 years? *If yes, please provide a signed affidavit disclosing the reason the entity was closed.*

Yes_____ No_____

8a. Has anyone listed in 8.d had an ownership interest of 5% or more in a pharmacy or any other business permit which was voluntarily relinquished or closed voluntarily within the past 5 years? *If yes, please provide a signed affidavit disclosing the reason the entity was closed.*

Yes _____ No _____

Pursuant to Section 465.022(5), the following questions are being asked. If you answer "Yes" to any of the following questions, explain on <u>a separate sheet</u> providing accurate details and submit copies of supporting documentation.
9. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant obtained a permit by misrepresentation or fraud?
Yes _____ No_____
10. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation?
Yes _____ No _____
11. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy?
Yes _____ No_____
12. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud?
Yes_____ No_____
13. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009?
Yes _____ No_____
14. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period?
Yes _____ No _____
15. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period?
Yes _____ No _____
16. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5-year period and the termination occurred at least 20 years before the date of the application?
Yes _____ No _____

17. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health Human Services Office of Inspector General's List of Excluded Individuals and Entities? *(If yes, please submit proof.)*

Yes _____ No _____

18. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466?

Yes _____ No _____

19. Are you currently registered or permitted in any other states? *(If yes, provide the state, permit type and permit number for each permit. Attach a separate sheet if necessary.)*

Yes_____ No _____

State	Permit Type	Permit Number

20. Has the applicant, affiliated persons, partners, officer, directors, or Consultant Pharmacist of Record ever owned a pharmacy? *(If yes, provide the name of the pharmacy, the state where the pharmacy is located and the status of the pharmacy. Attach a separate sheet if necessary.*

Yes _____ No _____

Individual's Name	Pharmacy Name	State	Status

21. Has any disciplinary action ever been taken against any license, permit or registration issued to the applicant, affiliated persons, partners, officers, directors or consultant pharmacist of record?

Yes _____ No _____

22. Has the applicant, affiliated person, partner, officer, or director ever been convicted of a felony or misdemeanor, excluding minor traffic convictions? You must include all misdemeanors and felonies, even if adjudication was withheld by the court, so that you would not have a record of conviction.

Yes _____ No _____

23. Does the applicant, affiliated person, partner, officer, director have any outstanding fines, liens or overpayments assessed by a final order of the department? *(If yes, please answer question #23a,)*

Yes _____ No _____

23a. Does the applicant, affiliated person, partner, officer, director have a repayment plan approved by the department?

Yes _____ No _____

SECTION B. Please complete for Change of Location only.

1. Current Practice Location Address

City	State	Zip

E-Mail Address** (see note below)	Telephone Number

2. New Practice Location Address

City	State	Zip

E-Mail Address** (see note below)	Telephone Number

Please provide your existing Pharmacy Permit Number:

Please provide your existing federal DEA Number:

NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

SECTION C. Please complete for Change of Ownership only.

1. Are you changing physical locations with this change of ownership?

Yes _____ No _____ *NOTE: If yes, please complete **Section B** above.*

2. Please provide date when business transaction for the change of ownership will be completed?

Date:

3. Do you have a signed letter from both the buyer and seller which indicates dates that pharmacy permit license should be transferred? *NOTE: A copy of the signed letter should be provided with your application.*

Yes _____ No _____

SECTION D. Please complete for Stock Transfer of Ownership only.

1. Please provide the date when the transfer of ownership interest took place?

Date:

2. Did your company's FEIN change as a result of the transfer of ownership interest referenced in Section D, Question 1 above?

Yes_____ No _____ *NOTE: If yes, please complete **Section C** above and include necessary fee.*

ALL QUESTIONS MUST BE ANSWERED OR YOUR APPLICATION WILL BE RETURNED

****

Section 456.013(1), F.S., requires that applicants supplement their applications as needed to reflect any material change in any circumstances or conditions stated in the application, which takes place between the initial filing of the application and the final grant or denial of the license, which might affect the decision of the department.

I swear and affirm that the statements contained in this application are true, complete, and correct and I agree that said statements shall form the basis of my application and I do authorize the Florida Board of Pharmacy to make any investigations that they deem appropriate and to secure any additional information concerning me, and I further authorize them to furnish any information they may have or have in the future concerning me to any person, corporation, institution, association, Board, or any municipal, county, state, or federal governmental agencies or units, and I understand according to the Florida Board of Pharmacy Statutes that a Pharmacy Permit may be revoked or suspended for presenting any false, fraudulent, or forged statement, certificate, diploma, or other item, in connection with an application for a license or permit, as set forth in Section 465.015(2)(a), F.S.

Under penalty of perjury I have read the foregoing document and that the facts stated in it are true. I recognize that providing false information may result in disciplinary action against my license or criminal penalties.

SIGNATURE _____ DATE_____
(Owner or officer of establishment)

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.
Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice, Federal Bureau of Investigation,
Criminal Justice Information Services Division

Privacy Statement

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as my be relevant to the activity for which this application is being submitted, the FBI(may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law , treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Electronic Fingerprinting

Take this form with you to the Live Scan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at: http://www.doh.state.fl.us/mqa/background.html;
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the livescan service provider the Board office will not receive your background screening results;
- You must provide accurate demographic information to the livescan service provider at the time your fingerprints are taken, ***including your Social Security number (SSN)***;
- The ORI number for the Board of Pharmacy is **EDOH4680Z**.
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name:_____ SSN#: _____ - ____ - _____

Aliases:_____

Address: _____ Apt. Number: _____

City:_____ State: _____Zip Code: _____

Date of Birth: _____/_____/_____ Place of Birth: _____
(MM/DD/YYYY)

Weight: _____ Height: _____ Eye Color:_____ Hair Color: _____

Race: _____
(W-White/Latino(a); B-Black; A-Asian;
NA-Native American; U-Unknown)

Sex: _____
(M=Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#):_____
(*This will be provided to you by the Live Scan Service provider*.)

Keep this form for your records.

Item #1- Consultant Pharmacist of Record Designation and Privacy Statement Acknowledgement

To: **Florida Board of Pharmacy**
Post Office Box 6320
Tallahassee, FL 32314-6320
(850) 245-4292- phone
(850) 413-6982 - fax
info@floridaspharmacy.gov

File #: (if known):
License #: (if applicable):

Section A. Consultant Pharmacist of Record (COR) Designation

Applicant/Pharmacy Name:		
Applicant/Pharmacy Mailing Address:		
City	**State**	**Zip**
Incoming COR Name:		**License#:**
		PU
Date Beginning as COR:	**Incoming COR Signature**	
COR Transaction Control Number (TCN) – related to Livescan Fingerprints:		
****OPTIONAL: Only provide following information if there is an Outgoing COR at current pharmacy****		
Outgoing COR Name:		**License#:**
		PU
Date Ending as COR:	**Outgoing COR Signature**	

Section B. Incoming COR Privacy Statement Acknowledgement

Note: Acknowledgment should be completed by same person listed in Section A above as Incoming COR.

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

Date:	**Incoming COR Signature**

Item #2- Affiliate/Owner Privacy Statement Acknowledgement

To be completed by EACH Affiliate/Owner listed in the application.

To: **Florida Board of Pharmacy, Post Office Box 6320, Tallahassee, FL 32314-6320**
(850) 245-4292- phone * (850) 413-6982 – fax * MQAPharmPDMAffiliate@flhealth.gov

From:

Affiliate / Owner Name:		**File # (required):**
Applicant Name:		
Affiliate/Owner Mailing Address:		
City	**State**	**Zip**
Affiliate/Owner E-Mail ** (see note below)	**Affiliate/Owner Telephone Number**	
Affiliate/Owner Transaction Control Number (TCN) – related to Livescan Fingerprints:		
NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.		

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

_____ _____

Affiliate/Owner Signature (Required) **Date (of signature)**

Item #3 - Policy and Procedure Questions

To be completed by Institutional Class II Pharmacy Permit Applicants

The Consultant Pharmacist of Record is responsible for developing and maintaining a current policy and procedure manual. A copy of the permittee's policy and procedure manual as provided herein shall accompany the permit application. The original policy and procedure manual shall be kept within the Modified Class II Institutional Pharmacy and shall be available for inspection by the Department of Health. The board office will approve the policy and procedure manual based upon answers submitted for the following questions, where applicable, by using excerpts or summaries from the policy and procedure manual.

1) List the following:
   Firm Name:
   Doing business as (d/b/a):
   Telephone number: Address:
   Permit number (if already licensed as an institutional pharmacy):

2) Explain the practice setting of the proposed facility.

3) What are the objectives and purpose of the permittee? Give detailed explanation of the services of the facility scope and practice.

4) What are the experience, qualifications, special education, and/or training of the compounding pharmacist? Please provide a resume.

5) Address the ratio of supportive personnel to each pharmacist. How will the supportive personnel be utilized? Include a job description for any such supportive personnel.

6) Describe the drug delivery system. Begin with the ordering of medications and track your procedures up to delivery to the patient. If utilizing remote medication order processing and the pharmacist is not an employee of the institution, describe the pharmacist and institution's responsibility.

7) What categories of parenteral/enteral products will be prepared (i.e. IV, enteral, irrigating, and oncology products)? Include sample labels.

8) What is the policy regarding the delivery of parenteral/enteral products to the patient? Describe methods used and trace the path the product takes from the time it leaves the permittee until it reaches the patient. Describe how products are protected from extreme temperature conditions.

9) Address the policy and procedure, special equipment and special techniques to dispense sterile preparations for parenteral therapy/nutrition. If this type of dispensing will not be performed, please state so accordingly.

10) Address the policy and procedure, special equipment and special techniques to dispense sterile jejunostomy feeding/sterile irrigation solutions. If this type of dispensing will not be performed, please state so accordingly.

11) Address the policy and procedure, special equipment and special techniques to dispense cytotoxic or anti-neoplastic agents. If this type of dispensing will not be performed, please state so accordingly.

12) What is the procedure for the annual review and updating of the policy and procedure manual?

13) Include the layout/floor plan of the pharmacy. The drawing must include the dimensions of the clean room and the pharmacy, location of the hood, sink and other equipment. The drawing must also show the location of the clean room relative to other pharmacy and storage areas.

14) Include a sample copy of a patient profile.

15) Address the use of aseptic techniques.

16) Describe the Quality Assurance Program.

17) Describe with detail the policy and procedure for patient education, including the personnel involved.

18) Address the policy and procedure for handling waste and returns.

19) Describe the type of certified laminar flow hood(s) used and the frequency of certification.

20) Describe the refrigerator/freezer to be used.

21) Describe appropriate waste containers for:

    a. Used needles and syringes.

    b. Cytotoxic waste including disposable apparel used in preparation.

22) Address the following supplies to be used: gloves, mask, gowns, needles, syringes, disinfectant cleaning agents, clean towels, hand-washing materials with bactericidal properties, vacuum containers/transfer sets, and spill kits for cytotoxic agent spills.

23) Address the following references to be used:

    a. Chapters 465 and 893, F.S., and Rule Title 64B16,F.A.C.
    b. Authoritative Therapeutic Reference.
    c. Handbook of injectable drugs by American Society of Health-System Pharmacists.

24) Occupational Safety and Health Administration guidelines for safe handling of cytotoxic drugs.

Item #4 - Policy and Procedure Questions

To be completed by Modified Institutional Class II Pharmacy Permit Applicants

Modified Institutional Class II pharmacies are those institutional pharmacies in short-term, primary care treatment centers that meet all the requirements for a Class II permit, except space and equipment requirements. Modified Class II Institutional pharmacies are designated as Type "A", Type "B" and Type "C" according to the type of specialized pharmaceutical delivery system utilized. Please review Rule 64B16-28.702, Florida Administrative Code for specific requirements.

The Consultant Pharmacist of Record is responsible for developing and maintaining a current policy and procedure manual. A copy of the permittee's policy and procedure manual as provided herein shall accompany the permit application. The original policy and procedure manual shall be kept within the Modified Class II Institutional Pharmacy and shall be available for inspection by the Department of Health. The board office will approve the policy and procedure manual based upon answers submitted for the following questions, where applicable, by using excerpts or summaries from the policy and procedure manual

1) List the following:
   Firm Name:
   Doing business as (d/b/a):
   Telephone number:
   Address:
   Consultant pharmacist of record:

2) Describe the purpose of the establishment. What sector of the community are you serving?

3) Is this is an inpatient facility? If so, how many beds are housed in the facility?
   What is the average length of stay?

4) List the drug formulary to be used.

5) Include a diagram of pharmacy storage space and a description of drug security measures.

6) Describe the consultant pharmacist of record's responsibilities.

7) Under whose DEA registration will controlled substances be ordered?

8) Describe the drug delivery system. Begin with the ordering of medications and track your procedures up to delivery to the patient.

9) Include a statement that perpetual inventory records will be maintained for controlled substances and injectable inventory.

10) Include a statement to the effect that no drugs will be dispensed from the facility.

If compounding sterile preparations, please answer the additional questions below.

11) If compounding sterile preparations, describe compliance with Rule 64B16- 27.797, F.A.C.

12) What categories of parenteral/enteral products will be prepared (i.e. IV, enteral, irrigating, and oncology products)? Include sample labels.

13) What is the policy regarding the delivery of parenteral/enteral products to the patient? Describe methods used and trace the path the product takes from the time it leaves the permittee until it reaches the patient. Describe how this product is protected from extreme temperature conditions.

14) Address the policy and procedure, special equipment and special techniques to dispense sterile preparations for parenteral therapy/nutrition. If this type of dispensing will not be performed, please state so accordingly.

15) Address the policy and procedure, special equipment and special techniques to dispense sterile jejunostomy feeding/sterile irrigation solutions. If this type of dispensing will not be performed, please state so accordingly.

16) Address the policy and procedure, special equipment and special techniques to dispense cytotoxic or anti-neoplastic agents. If this type of dispensing will not be performed, please state so accordingly.

17) What is the procedure for the annual review and updating of the policy and procedure manual?

18) Include the layout/floor plan of the pharmacy. The drawing must include the dimensions of the clean room and the pharmacy, location of the hood, sink and other equipment. The drawing must also show the location of the clean room relative to other pharmacy and storage areas.

19) Include a sample copy of a patient profile.

20) Address the use of aseptic techniques.

21) Describe the Quality Assurance Program.

22) Describe with detail the policy and procedure for patient education, including the personnel involved.

23) Address the policy and procedure for handling waste and returns.

24) Describe the type of certified laminar flow hood(s) to be used and the frequency of certification.

25) Describe the refrigerator/freezer to be used.

26) Describe appropriate waste containers for:
    a. Used needles and syringes.
    b. Cytotoxic waste including disposable apparel used in preparation.

27) Address the following supplies to be used: gloves, mask, gowns, needles, syringes, disinfectant cleaning agents, clean towels, hand-washing materials with bactericidal properties, vacuum containers/transfer sets, and spill kits for cytotoxic agent spills.

28) Address the following references to be used:
    a. Chapters 465 and 893, F.S., and Title 64B16, F.A.C.
    b. Authoritative Therapeutic Reference.
    c. Handbook of Injectable Drugs by American Society of Health-System Pharmacists.
    d. Occupational Safety and Health Administration guidelines for safe handling of cytotoxic drugs.

DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF PHARMACY
4052 BALD CYPRESS WAY, BIN #C-04
TALLAHASSEE, FLORIDA 32399-3254
(850) 245-4292

INTERNET PHARMACY PERMIT APPLICATION AND INFORMATION

January 2018

Dear Florida Pharmacy Permit Applicant,

Thank you for applying for a pharmacy permit in the State of Florida. The information in this packet has been designed to provide the essential information required to process your application in a timely manner. Your assistance in providing all required information will enable the Florida Board of Pharmacy (the Board) staff to process your application as soon as possible. You are encouraged to apply as early as possible to avoid processing delays caused by large volumes of applicants.

Florida Statutes require a completed application and fees before your application can be reviewed. Please read these instructions carefully and fully before submitting your application. You should keep a copy of the completed application and all other materials sent to the Board office for your records. When you mail the completed application and fees, use the address noted in the instructions and on the application form.

When your application arrives, your fees will be deposited and verified before the staff review can begin. You will receive a letter acknowledging receipt of your application. The staff will notify you within 30 days if any materials are incomplete.

If you need to communicate with the Board staff, you are encouraged to email the Board staff at info@floridaspharmacy.gov, or you may at call us at (850) 245-4292. Phone calls are returned within 24 hours and emails are responded to within 48 hours during normal business hours. Our staff is committed to providing prompt and reliable information to our customers. Many procedures have been streamlined to expedite the processing of applications; we certainly welcome your comments on how our services may be improved.

Sincerely,

The Board of Pharmacy

INTERNET PHARMACY PERMIT APPLICATION INFORMATION

Whether opening a new establishment, changing locations, or changing owners, a pharmacy permit is required prior to operating in the State of Florida. The permit application must be completed and returned to the Florida Board of Pharmacy with the required fee of $255.00. The application MUST have the original signatures of the owner or officer of the establishment and the Prescription Department Manager (PDM). If compounding sterile preparations, submit an additional application on Form DH-MQA 1270, "Special Sterile Compounding Permit" and pay the additional permitting fee.

An Internet Pharmacy as authorized by Section 465.0197, F.S., is required for any location not otherwise licensed or issued a permit under this chapter, within or outside this state that uses the Internet to communicate with or obtain information from consumers and uses the information to fill or refill prescriptions or to dispense, distribute, or otherwise engage in the practice of pharmacy in this state.

The Internet Pharmacy Permit is open at least 6 days per week for a minimum of 40 hours per week. A toll-free telephone number shall be provided to facilitate communication between patients in this state and a pharmacist in the pharmacy who has access to the patient's records.

Section 465.022(4), Florida Statutes, also provides that an application for a pharmacy permit must include the applicant's written policies and procedures for preventing controlled substance dispensing based on fraudulent representations or invalid practitioner-patient relationships. The policy and procedure manual shall contain the procedures implemented to minimize the dispensing of controlled substances based on fraudulent representations as follows:

1. Provisions to identify and guard against invalid practitioner-patient relationships.
2. Provisions to guard against filling fraudulent prescriptions for controlled substances.
3. Provisions to identify prescriptions that are communicated or transmitted legally.
4. Provisions to identify the characteristics of a forged or altered prescription.

Application Processing

Please read all application instructions before completing your application.

1) Please mail the application and the $255.00 application fee (check or money order made payable to the FLORIDA DEPARTMENT OF HEALTH) to the following address:

Application & Fees:
Department of Health
Board of Pharmacy
P.O. Box 6320
Tallahassee, Florida 32314-6320

Express Mail ONLY
Department of Health
Board of Pharmacy
4052 Bald Cypress Way, Bin C-04
Tallahassee, FL 32399-3254

Within 30 days of receipt of your application and fees, the board office will notify you of the receipt of your application, any required documents, and your status. If the application is complete, you will be notified that an inspector will contact you to setup an inspection appointment. Please do not contact the board office concerning your inspection date, and allow 30 days for the inspector to contact you. If you have not been contacted by the inspector within 30 days, then notify the board. If your application is incomplete, you will be notified in writing of what is required to make your application complete.

2) Submit fingerprint results.

Failure to submit fingerprints will delay your application. All owners, officers, and PDMs are required to submit a set of fingerprints unless the corporation is exempt under the Section 465.022, Florida Statutes, for corporations having more than $100 million of business taxable assets in this state. These corporations are only required to have the PDM to submit fingerprints. **Note: If your officer, owner, or PDM has already been fingerprinted at the time you are completing this Community Pharmacy permit application, please ensure to provide the Transaction Control Number (TCN) with the requested information in the application.**

Applicants may use any Livescan vendor that has been approved by the Florida Department of Law Enforcement to submit their fingerprints to the department. Please ensure that the Originating Agency Identification (ORI) number is provided to the vendor when you submit your fingerprints. If you do not provide an ORI number or if you provide an incorrect ORI number to the vendor, the Board of Pharmacy will not receive your fingerprint results. The applicant is fully responsible for selecting the vendor and ensuring submission of the prints to the Department.

How do I find a Livescan vendor in order to submit my fingerprints to the Department?
The Department of Health accepts electronic fingerprinting service offered by Livescan device vendors that are approved by the Florida Department of Law Enforcement and listed at their site. You can view the vendor options and contact information at:

http://www.floridahealth.gov/licensing-and-regulation/background-screening/livescan-service-providers.html

What information must I provide to the Livescan vendor I choose?

- If you are an applicant seeking a license for any profession regulated by the Department of Health, which requires a criminal background search as a condition of licensure, you must provide accurate demographic information at the time your fingerprints are taken, ***including your Social Security number***. The Department will not be able to process a submission that does not include your Social Security number.
- You must provide the correct ORI number.

Where do I get the ORI number to submit to the vendor?

- The ORI number for the pharmacy profession is **EDOH4680Z.**

Attestation for Business Taxable Assets

- If the applicant has more than $100 million dollars of business taxable assets in this state, please submit a formal opinion letter from a Certified Public Accountant duly licensed in the state of your principal place of business affirming the corporation has more than $100 million of business taxable assets in this state for the previous tax year. In lieu of submitting a formal opinion letter from a Certified Public Accountant, the applicant may submit a copy of its Florida Corporate Income/Franchise and Emergency Excise Tax Return (Form F-1120, Effective 01/09).

3) Privacy Statement and Attestation

In order for the Board of Pharmacy Office to receive your Livescan electronic fingerprinting results, you must affirm that you have been provided with and read the attached statement from the Florida Department of Law Enforcement regarding the sharing, retention, and right to challenge incorrect criminal history records, and the "Privacy Statement" document from the Federal Bureau of Investigation. The appropriate form(s) to provide this affirmation are included within Items #1 and #2 of the application.

Licensure Process

Once the application is deemed complete, the Board staff authorizes an inspection. Upon completion of the inspection, the inspector notifies the Board office as to whether the inspection was satisfactory or unsatisfactory. If the inspection is satisfactory, a permit number is issued within 7-10 days. You will receive the actual copy of your license within 7 days. **Please wait 7-14 days from your satisfactory inspection before checking on the status of your permit with the Board office**.

You may look up your license number on our website at http://www.flhealthsource.com/ under "Verify a License."

The Board recognizes that a delay may exist between the time a pharmacy receives a Florida pharmacy permit and commences to operate. Accordingly, upon receipt of Community Pharmacy permit, a pharmacy may delay commencement of operations in compliance with the requirements provided in Rule 64B16-28.1081, F.A.C.

Drug Enforcement Administration (DEA)

Please note that the DEA will not issue a registration until the Florida Board of Pharmacy has issued a pharmacy permit. More information is available by visiting the DEA website at http://www.DEAdiversion.usdoj.gov, or by contacting them at (800)667-9752.

IMPORTANT NOTICE: Pursuant to Section 465.022(5), F.S., the Department or Board shall deny an application for a pharmacy permit if the applicant or an affiliated person, partner, officer, director, or prescription department manager or consultant pharmacist of record of the applicant:

(a) Has obtained a permit by misrepresentation or fraud.

(b) Has attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation.

(c) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy.

(d) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud.

(e) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, since July 1, 2009.

(f) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009.

(g) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period.

(h) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5-year period and the termination occurred at least 20 years before the date of the application.

(i) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

(j) Has dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466.

For felonies in which the defendant entered a plea of guilty or nolo contendere in an agreement with the court to enter a pretrial intervention or drug diversion program, the department shall deny the application if upon final resolution of the case the licensee has failed to successfully complete the program.

<u>If applicable to you, please provide the documentation to the Florida Board of Pharmacy.</u>

INTERNET PHARMACY PERMIT APPLICATION CHECKLIST

Keep a copy of the completed application for your records.

It is recommended that you use the following checklist to help ensure that your application is complete. Failure to attach any required document, or to have required documentation sent to the Board, will result in an incomplete application. Final approval for inspection cannot be granted until the application is complete.

INTERNET PHARMACY PERMIT

_____All Application Questions Answered?

_____$255.00 Fee Attached (Permit fee includes $250 application fee and $5.00 unlicensed activity fee)

_____Articles of Incorporation paperwork from the Secretary of State provided?

_____PDM Designation and Privacy Statement Acknowledgement provided (Application Item #1)?

_____Affiliate/Owner Privacy Statement Acknowledgement provided for each affiliate/owner (Application Item #2)?

_____Applicant/Affiliate/Owner supplemental documents provided for explaining any previous ownership, disciplinary actions, voluntary relinquishments and/or criminal activity?

_____Applicant/Affiliate/Owner pharmacy permit questions answered and supplemental documents provided?

_____Policies and Procedures for preventing controlled substance dispensing based on fraudulent representations or invalid practitioner-patient relationships submitted?

FLORIDA BOARD OF PHARMACY
P.O. Box 6320
Tallahassee, FL 32314-6320
Telephone (850) 488-0595
http://www.floridaspharmacy.gov

INTERNET PHARMACY PERMIT

APPLICATION

Application Type – Please choose one of the following:

___New Establishment ($255.00 fee)
Complete: Section A only, along with Items #1 and 2.

___Change of Ownership ($255.00 fee)
Complete: Sections A and C only, along with Items #1 and 2

___ Change of Location ($100.00 fee)
Complete: Sections A and B only.

___ Stock Transfer (no fee)
Complete: Section A, pages 2-3 and Section D only.

SECTION A. Please complete for all Application Types

Please list your Federal Employer Identification Number:

1. Corporate Name	Telephone Number

2. Doing Business As (d/b/a)	E-Mail Address** (see note below)

3. Mailing Address		
City	State	Zip

4. Physical Address		
City	State	Zip

5. Prescription Department Manager (PDM) Information	
Name	License Number
E-Mail Address** (see note below)	Telephone Number

6. Contact Person	Title
E-Mail Address** (see note below)	Telephone Number

NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

7. Operating Hours

Is the pharmacy least 6 days per week for a minimum of 40 hours per week? Yes_____ No_____

Please provide Toll-Free Telephone Number? _____

8. Ownership Information

a. Type of Ownership: _____Individual _____Corporation _____Partnership

NOTE: If the applicant is a corporation or limited partnership you must include with your application a copy of the Articles of Incorporation on file with the Florida Secretary of State's office.

b. Are the applicants, officers, directors, shareholders, members and partners over the age of 18?

Yes _____ No _____

c. Does the corporation have more than $100 million of business taxable assets in this state?

Yes _____ No _____ If yes, provide attestation from Certified Public Accountant for previous tax year or Florida Corporate Income/Franchise and Emergency Excise Tax Return (F-1120). If no, continue to 12d.

d. List all the owners and officers of the corporation. Each person listed below having an ownership interest of 5% or greater and any person who, directly or indirectly, manages, oversees, or controls the operation of the applicant including officers and members of the board of directors must submit a set of fingerprints and fees unless you answered yes to 8c. If 8c is "Yes", please list the owners below and only submit fingerprints for the Prescription Department Manager. If 8c is "Yes" and the prints are on file with DOH or AHCA and available to the Board of Pharmacy, the requirement to submit the prints for this person is met. Also, if the % of Ownership column does not add to 100%, please provide an explanation. *Attach a separate sheet if necessary.*

Owner/Officer-Title	Date of Birth	Mailing Address, City, State, Zip Code	% of Ownership
	/ /		%
	/ /		%
	/ /		%
	/ /		%
	/ /		%

9. Has anyone listed in 8.d had an ownership interest of 5% or more in a pharmacy or any other business permit which was disciplined, suspended, revoked, or closed involuntarily within the past 5 years? *If yes, please provide a signed affidavit disclosing the reason the entity was closed.*

Yes _____ No _____ .

9a. Has anyone listed in 8.d had an ownership interest of 5% or more in a pharmacy or any other business permit which was voluntarily relinquished or closed voluntarily within the past 5 years?
If yes, please provide a signed affidavit disclosing the reason the entity was closed.

Yes _____ No _____

Pursuant to Section 465.022(5), the following questions are being asked. If you answer "Yes" to any of the following questions, explain on a separate sheet providing accurate details and submit copies of supporting documentation.
10. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant obtained a permit by misrepresentation or fraud?
Yes _____ No_____
11. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation?
Yes _____ No _____
12. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy?
Yes _____ No_____
13. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud?
Yes_____ No_____
14. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, since July 1, 2009?
Yes _____ No_____
15. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009?
Yes _____ No _____
16. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period?
Yes _____ No _____
17. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5-year period and the termination occurred at least 20 years before the date of the application?
Yes _____ No _____
18. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health Human Services Office of Inspector General's List of Excluded Individuals and Entities? *(If yes, please submit proof.)*
Yes _____ No _____

19. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466?

Yes_____ No_____

20. Are you currently registered or permitted in any other states? *(If yes, provide the state, permit type and permit number for each permit. Attach a separate sheet if necessary.)*

Yes _____ No ____

State	Permit Type	Permit Number

21. Has the applicant, affiliated person, partner, officer, directors, or Prescription Department Manager ever owned a pharmacy? *(If yes, provide the name of the pharmacy, the state where the pharmacy is located and the status of the pharmacy. Attach a separate sheet if necessary.)*

Yes _____ No____

Individual's Name	Pharmacy Name	State	Status

22. Has any disciplinary action ever been taken against any license, permit or registration issued to the applicant, affiliated person, partner, officer, director, or Prescription Department Manager?

Yes _____ No____

23. Has the applicant, affiliated person, partner, officer, or director ever been convicted of a felony or misdemeanor, excluding minor traffic convictions? You must include all misdemeanors and felonies, even if adjudication was withheld by the court, so that you would not have a record of conviction.

Yes____ No____

24. Does the applicant, affiliated person, partner, officer, or director have any outstanding fines, liens or overpayments assessed by a final order of the department? If yes please answer 24a.

Yes____ No_____

24a. Does the applicant, affiliated person, partner, officer, or director have a repayment plan approved by the department?

Yes____ No_____

25. Will the Pharmacy Dispense Schedule II and/or III Controlled Substances?

Yes____ No_____

SECTION B. Please complete for Change of Location only.

1. Current Practice Location Address

City	State	Zip

E-Mail Address** (see note below)	Telephone Number

2. New Practice Location Address

City	State	Zip

E-Mail Address** (see note below)	Telephone Number

Please provide your existing Pharmacy Permit Number:

Please provide your existing federal DEA Number:

NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

SECTION C. Please complete for Change of Ownership only.

1. Are you changing physical locations with this change of ownership?

Yes _____ No _____ *NOTE: If yes, please complete **Section B** above.*

2. Please provide date when business transaction for the change of ownership will be completed?

Date: _____

3. Do you have a signed letter from both the buyer and seller which indicates dates that pharmacy permit license should be transferred? *NOTE: A copy of the signed letter should be provided with your application.*

Yes _____ No _____

SECTION D. Please complete for Stock Transfer of Ownership only.

1. Please provide the date when the transfer of ownership interest took place?

Date: _____

2. Did your company's FEIN change as a result of the transfer of ownership interest referenced in Section D, Question 1 above?

Yes _____ No _____ *NOTE: If yes, please complete **Section C** above and include necessary fee.*

ALL QUESTIONS MUST BE ANSWERED OR YOUR APPLICATION WILL BE RETURNED

****

* Section 456.013(1), F.S., requires that applicants supplement their applications as needed to reflect any material change in any circumstances or conditions stated in the application, which takes place between the initial filing of the application and the final grant or denial of the license, which might affect the decision of the department.

I swear or affirm that the statements contained in this application are true, complete, and correct and I agree that said statements shall form the basis of my application and I do authorize the Florida Board of Pharmacy to make any investigations that they deem appropriate and to secure any additional information concerning me, and I further authorize them to furnish any information they may have or have in the future concerning me to any person, corporation, institution, association, Board, or any municipal, county, state, or federal governmental agencies or units, and I understand according to the Florida Board of Pharmacy Statutes that a Pharmacy Permit may be revoked or suspended for presenting any false, fraudulent, or forged statement, certificate, diploma, or other item, in connection with an application for a license or permit, as set forth in Section 465.015(2)(a), F.S.

Under penalty of perjury I have read the foregoing document and that the facts stated in it are true. I recognize that providing false information may result in disciplinary action against my license or criminal penalties.

SIGNATURE _____ DATE_____
(Owner or officer of establishment)

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.

Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice, Federal Bureau of Investigation,
Criminal Justice Information Services Division

Privacy Statement

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as my be relevant to the activity for which this application is being submitted, the FBI(may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law , treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Electronic Fingerprinting

Take this form with you to the Livescan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at: http://www.doh.state.fl.us/mqa/background.html
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider the Board office will not receive your background screening results;
- You must provide accurate demographic information to the livescan service provider at the time your fingerprints are taken, ***including your Social Security number (SSN)***;
- The ORI number for the Board of Pharmacy is **EDOH4680Z.**
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name:_____ SSN#: _____ - ____ - _____

Aliases:_____

Address: _____ Apt. Number: _____

City:_____ State: _____Zip Code: _____

Date of Birth: _____/_____/_____ Place of Birth: _____
(MM/DD/YYYY)

Weight: _____ Height: _____ Eye Color:_____ Hair Color: _____

Race: _____ Sex: _____

Citizenship: _____
(W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown) (M=Male; F=Female)

Transaction Control Number (TCN#):_____
(*This will be provided to you by the Live Scan Service provider*.)

Keep this form for your records.

Item #1- PDM Designation and Privacy Statement Acknowledgement

File #: (if known):
License #: (if applicable):

To: **Florida Board of Pharmacy**
Post Office Box 6320
Tallahassee, FL 32314-6320
(850) 245-4292- phone
(850) 413-6982 - fax
info@floridaspharmacy.gov

Section A. Prescription Department Manager (PDM) Designation

Applicant/Pharmacy Name:		
Applicant/Pharmacy Mailing Address:		
City	**State**	**Zip**
Incoming PDM Name:		**License#:**
Date Beginning as PDM:	**Incoming PDM Signature**	
PDM Transaction Control Number (TCN) – related to Livescan Fingerprints:		
Only provide following information is there is an Outgoing PDM at current pharmacy location.		
Outgoing PDM Name:		**License#:**
Date Ending as PDM:	**Outgoing PDM Signature**	

Section B. Incoming PDM Privacy Statement Acknowledgement

Note: Acknowledgment should be completed by same person listed in Section A above as Incoming PDM.

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

Date:	Incoming PDM Signature

Item #2- Affiliate/Owner Privacy Statement Acknowledgement

To be completed by EACH Affiliate/Owner listed in the application.

To: **Florida Board of Pharmacy, Post Office Box 6320, Tallahassee, FL 32314-6320**
(850) 245-4292- phone * (850) 413-6982 – fax * MQAPharmPDMAffiliate@flhealth.gov

From:

Affiliate / Owner Name:		**File # (required):**
Applicant Name:		
Affiliate/Owner Mailing Address:		
City	**State**	**Zip**
Affiliate/Owner E-Mail ** (see note below)	**Affiliate/Owner Telephone Number**	
Affiliate/Owner Transaction Control Number (TCN) – related to Livescan		
NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.		

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

_____ _____

Affiliate/Owner Signature (Required) **Date (of signature)**

DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF PHARMACY
4052 BALD CYPRESS WAY, BIN #C-04
TALLAHASSEE, FLORIDA 32399-3254
(850) 245-4292

NUCLEAR PHARMACY PERMIT APPLICATION AND INFORMATION

January 2018

Dear Florida Pharmacy Permit Applicant,

Thank you for applying for a pharmacy permit in the State of Florida. The information in this packet has been designed to provide the essential information required to process your application in a timely manner. Your assistance in providing all required information will enable the Florida Board of Pharmacy (the Board) staff to process your application as soon as possible. You are encouraged to apply as early as possible to avoid processing delays caused by large volumes of applicants.

Florida Statutes require a completed application and fees before your application can be reviewed. Please read these instructions carefully and fully before submitting your application. You should keep a copy of the completed application and all other materials sent to the Board office for your records. When you mail the completed application and fees, use the address noted in the instructions and on the application form.

When your application arrives, your fees will be deposited and verified before the staff review can begin. You will receive a letter acknowledging receipt of your application. The staff will notify you within 30 days if any materials are incomplete.

If you need to communicate with the Board staff, you are encouraged to email the Board staff at info@floridaspharmacy.gov, or you may at call us at (850) 245-4292. Phone calls are returned within 24 hours and emails are responded to within 48 hours during normal business hours. Our staff is committed to providing prompt and reliable information to our customers. Many procedures have been streamlined to expedite the processing of applications; we certainly welcome your comments on how our services may be improved.

Sincerely,

The Board of Pharmacy

NUCLEAR PHARMACY PERMIT APPLICATION INFORMATION

Whether opening a new establishment, changing locations, or changing owners, a pharmacy permit is required prior to operating in the State of Florida. The permit application must be completed and returned to the Florida Board of Pharmacy with the required fee of $255.00. The application MUST have the original signatures of the owner or officer of the establishment and the Prescription Department Manager (PDM). If compounding sterile preparations, submit an additional application on Form DH-MQA 1270, "Special Sterile Compounding Permit" and pay the additional permitting fee.

Nuclear pharmacy permits as authorized by Section 465.0193, F.S., are required for every location where radioactive drugs and chemicals within the classification of medicinal drugs are compounded, dispensed, stored, or sold. Chapter 465, F.S., requires Nuclear Pharmacies to be under the professional supervision of the Nuclear Pharmacist of Record licensed in the State of Florida as the Prescription Department Manager (PDM). The Prescription Department Manager (PDM) is responsible for ensuring the pharmacy permittee's compliance with all statutes and rules governing the practice of the profession of pharmacy, including maintenance of all drug records and ensuring the security of the prescription department, and shall competently and diligently exercise their responsibilities as a prescription department manager. Please see Rule 64B16-27.450, F.A.C., for more information.

Section 465.022(4), Florida Statutes, also provides that an application for a pharmacy permit must include the applicant's written policies and procedures for preventing controlled substance dispensing based on fraudulent representations or invalid practitioner-patient relationships. The policy and procedure manual shall contain the procedures implemented to minimize the dispensing of controlled substances based on fraudulent representations as follows:

1. Provisions to identify and guard against invalid practitioner-patient relationships.
2. Provisions to guard against filling fraudulent prescriptions for controlled substances.
3. Provisions to identify prescriptions that are communicated or transmitted legally.
4. Provisions to identify the characteristics of a forged or altered prescription.

Application Processing

Please read all application instructions before completing your application.

1) Please mail the application and the $255.00 application fee (cashiers check or money order made payable to the FLORIDA DEPARTMENT OF HEALTH) to the following address:

Application & Fees:
Department of Health
Board of Pharmacy
P.O. Box 6320
Tallahassee, Florida 32314-6320

Express Mail ONLY
Department of Health
Board of Pharmacy
4052 Bald Cypress Way, Bin C-04
Tallahassee, FL 32399-3254

Within 30 days of receipt of your application and fees, the Board office will notify you of the receipt of your application, any required documents, and your status. If the application is complete, you will be notified that an inspector will contact you to setup an inspection appointment. If your application is incomplete, you will be notified in writing of what is required to make your application complete.

2) Submit fingerprint results.

Failure to submit fingerprints will delay your application. All owners, officers, and PDMs are required to submit a set of fingerprints unless the corporation is exempt under the Section 465.022, Florida Statutes, for corporations having more than $100 million of business taxable assets in this state. These corporations are only required to have the PDM to submit fingerprints. **Note: If your officer, owner, or PDM has already been fingerprinted at the time you are completing this Community Pharmacy permit application, please ensure to provide the Transaction Control Number (TCN) with the requested information in the application.**

Applicants may use any Livescan vendor that has been approved by the Florida Department of Law Enforcement to submit their fingerprints to the department. Please ensure that the Originating Agency Identification (ORI) number is provided to the vendor when you submit your fingerprints. If you do not provide an ORI number or if you provide an incorrect ORI number to the vendor, the Board of Pharmacy will not receive your fingerprint results. The applicant is fully responsible for selecting the vendor and ensuring submission of the prints to the Department.

How do I find a Livescan vendor in order to submit my fingerprints to the Department?
Department of Health accepts electronic fingerprinting service offered by Livescan device vendors that are approved by the Florida Department of Law Enforcement and listed at their site. You can view the vendor options and contact information at:

http://www.floridahealth.gov/licensing-and-regulation/background-screening/livescan-service-providers.html

What information must I provide to the Livescan vendor I choose?

- If you are an applicant seeking a license for any profession regulated by the Department of Health, which requires a criminal background search as a condition of licensure, you must provide accurate demographic information at the time your fingerprints are taken, ***including your Social Security number***. The Department will not be able to process a submission that does not include your Social Security number.
- You must provide the correct ORI number.

Where do I get the ORI number to submit to the vendor?

- The ORI number for the pharmacy profession is **EDOH4680Z.**

Attestation for Business Taxable Assets

- If the applicant has more than $100 million dollars of business taxable assets in this state, please submit a formal opinion letter from a Certified Public Accountant duly licensed in the state of your principal place of business affirming the corporation has more than $100 million of business taxable assets in this state for the previous tax year. In lieu of submitting a formal opinion letter from a Certified Public Accountant, the applicant may submit a copy of its Florida Corporate Income/Franchise and Emergency Excise Tax Return (Form F-1120, Effective 01/09).

3) Privacy Statement and Attestation

In order for the Board of Pharmacy Office to receive your Livescan electronic fingerprinting results, you must affirm that you have been provided with and read the attached statement from the Florida Department of Law Enforcement regarding the sharing, retention, and right to challenge incorrect criminal history records, and the "Privacy Statement" document from the Federal Bureau of Investigation. The appropriate form(s) to provide this affirmation are included within Items #1 and #2 of the application.

Licensure Process

Once the application is deemed complete, the Board staff authorizes an inspection. Upon completion of the inspection, the inspector notifies the Board office as to whether the inspection was satisfactory or unsatisfactory. If the inspection is satisfactory, a permit number is issued within 7-10 days. You will receive the actual copy of your license within 7 days. **Please wait 7-14 days from your satisfactory inspection before checking on the status of your permit with the Board office**.

You may look up your license number on our website at http://www.flhealthsource.com/ under "Verify a License."

Drug Enforcement Administration (DEA)

Please note that the DEA will not issue a registration until the Florida Board of Pharmacy has issued a pharmacy permit. More information is available by visiting the DEA website at http://www.DEAdiversion.usdoj.gov, or by contacting them at (800)667-9752.

IMPORTANT NOTICE: Pursuant to Section 465.022(5), F.S., the Department or Board shall deny an application for a pharmacy permit if the applicant or an affiliated person, partner, officer, director, or prescription department manager or consultant pharmacist of record of the applicant:

(a) Has obtained a permit by misrepresentation or fraud.

(b) Has attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation.

(c) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy.

(d) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud.

(e) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, since July 1, 2009.

(f) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009.

(g) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period.

(h) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5-year period and the termination occurred at least 20 years before the date of the application.

(i) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

(j) Has dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466.

For felonies in which the defendant entered a plea of guilty or nolo contendere in an agreement with the court to enter a pretrial intervention or drug diversion program, the department shall deny the application if upon final resolution of the case the licensee has failed to successfully complete the program.

<u>If applicable to you, please provide the documentation to the Florida Board of Pharmacy.</u>

NUCLEAR PHARMACY PERMIT APPLICATION CHECKLIST

Keep a copy of the completed application for your records.

It is recommended that you use the following checklist to help ensure that your application is complete. Failure to attach any required document, or to have required documentation sent to the Board, will result in an incomplete application. Final approval for inspection cannot be granted until the application is complete.

NUCLEAR PHARMACY PERMIT

_____All Application Questions Answered?

_____$255.00 Fee Attached (Permit fee includes $250 application fee and $5.00 unlicensed activity fee)

_____Articles of Incorporation paperwork from the Secretary of State provided?

_____PDM Designation and Privacy Statement Acknowledgement provided (Application Item #1)?

_____Affiliate/Owner Privacy Statement Acknowledgement provided for each affiliate/owner (Application Item #2)?

_____Applicant/Affiliate/Owner supplemental documents provided for explaining any previous ownership, disciplinary actions, voluntary relinquishments and/or criminal activity?

_____Applicant/Affiliate/Owner pharmacy permit questions answered and supplemental documents provided?

_____Policies and Procedures for preventing controlled substance dispensing based on fraudulent representations or invalid practitioner-patient relationships submitted?

FLORIDA BOARD OF PHARMACY
P.O. Box 6320
Tallahassee, FL 32314-6320
Telephone (850) 488-0595
http://www.floridaspharmacy.gov

NUCLEAR PHARMACY PERMIT

APPLICATION

Application Type – Please choose one of the following:

___New Establishment ($255.00 fee)
Complete: Section A only, along with Items #1, #2, and #3.

___Change of Ownership ($255.00 fee)
Complete: Sections A and C only, along with Items #1 and 2.

___ Change of Location ($100.00 fee)
Complete: Sections A and B only.

___ Stock Transfer (no fee)
Complete: Section A, pages 2-3 and Section D only.

SECTION A. Please complete for all Application Types

Please list your Federal Employer Identification Number: _____

1. Corporate Name	**Telephone Number**

2. Doing Business As (d/b/a)	**E-Mail Address**** (see note below)

3. Mailing Address		
City	**State**	**Zip**

4. Physical Address		
City	**State**	**Zip**

5. List the Nuclear Pharmacist of Record Information:

Name	**License#:**	
	PS	**NP**
E-Mail Address** (see note below)	**Telephone Number**	

6. Contact Person	**Title**
E-Mail Address** (see note below)	**Phone Number**

NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

7. Ownership Information

a. Type of Ownership: _____Individual _____Corporation _____Partnership

_____Other: _____

NOTE: IF CORPORATION OR LIMITED PARTNERSHIP YOU MUST INCLUDE WITH YOUR APPLICATION A COPY OF THE ARTICLES OF INCORPORATION ON FILE WITH THE FLORIDA SECRETARY OF STATE'S OFFICE.

b. Are the applicants, officers, directors, shareholders, members and partners over the age of 18?

Yes _____ No _____

c. Does the corporation have more than $100 million of business taxable assets in this state? *If yes, provide attestation from Certified Public Accountant for previous tax year or Florida Corporate Income /Franchise and Emergency Excise Tax Return (F-1120).*

Yes _____ No _____

d. List all the owners and officers of the corporation. Each person listed below having an ownership interest of 5% or greater and any person who, directly or indirectly, manages, oversees, or controls the operation of the applicant including officers and members of the board of directors must submit a set of fingerprints and fees unless you answered yes to 8c. If 8c is "Yes", please list the owners below and only submit fingerprints for the Prescription Department Manager. If 8c is "Yes" and the prints are on file with DOH or AHCA and available to the Board of Pharmacy, the requirement to submit the prints for this person is met. Also, if the % of Ownership column does not add to 100%, please provide an explanation. *Attach a separate sheet if necessary.*

Owner/Officer-Title	Date of Birth	Mailing Address, City, State, Zip Code	% of Ownership
	/ /		%
	/ /		%
	/ /		%
	/ /		%
	/ /		%
	/ /		%

8. Has anyone listed in 7.d had an ownership interest of 5% or more in a pharmacy or any other business permit which was disciplined, suspended, revoked, or closed involuntarily within the past 5 years? *If yes, please provide a signed affidavit disclosing the reason the entity was closed.*

Yes _____ No _____

8a. Has anyone listed in 7.d had an ownership interest of 5% or more in a pharmacy or any other business permit which was voluntarily relinquished or closed voluntarily within the past 5 years? *If yes, please provide a signed affidavit disclosing the reason the entity was closed.*

Yes _____ No _____

Pursuant to Section 465.022(5), the following questions are being asked. If you answer "Yes" to any of the following questions, explain <u>on a separate sheet</u> providing accurate details and submit copies of supporting documentation.
9. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant obtained a permit by misrepresentation or fraud?
Yes _____ No_____
10. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation?
Yes _____ No_____
11. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy?
Yes _____ No_____
12. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud?
Yes _____ No_____
13. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, since July 1, 2009?
Yes _____ No_____
14. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009?
Yes _____ No_____
15. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period?
Yes _____ No_____
16. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5-year period and the termination occurred at least 20 years before the date of the application?
Yes _____ No_____

17. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health Human Services Office of Inspector General's List of Excluded Individuals and Entities? *(If yes, please submit proof.)*

Yes _____ No _____

18. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466?

Yes_____ No ____

19. Are you currently registered or permitted in any other states? *(If yes, provide the state, permit type and permit number for each permit. Attach a separate sheet if necessary.)*

Yes _____No _____

State	Permit Type	Permit Number

20. Has the applicant, affiliated person, partner, officer, directors, or Prescription Department Manager ever owned a pharmacy? *(If yes, provide the name of the pharmacy, the state where the pharmacy is located and the status of the pharmacy. Attach a separate sheet if necessary.)*

Yes _____ No_____

Individual's Name	Pharmacy Name	State	Status

21. Has any disciplinary action ever been taken against any license, permit or registration issued to the applicant, affiliated person, partner, officer, director, or prescription department manager?

Yes _____ No_____

23. Has the applicant, affiliated person, partner, officer, or director ever been convicted of a felony or misdemeanor, excluding minor traffic convictions? You must include all misdemeanors and felonies, even if adjudication was withheld by the court, so that you would not have a record of conviction.

Yes _____ No_____

24. Does the applicant, affiliated person, partner, officer, director have any outstanding fines, liens or overpayments assessed by a final order of the department? *(If yes, please answer question #24a)*

Yes _____ No _____

24a. Does the applicant, affiliated person, partner, officer, director have a repayment plan approved by the department? *(If yes, explain on a separate sheet providing accurate details.)*

Yes _____ No _____

SECTION B. Please complete for a Change of Location only

1. Current Practice Location Address

City	State	Zip

E-Mail Address** (see note below)	Telephone Number

2. New Practice Location Address

City	State	Zip

E-Mail Address** (see note below)	Telephone Number

Please provide your existing Pharmacy Permit Number(s):

Please provide your existing Federal DEA Number:

NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

SECTION C. Please complete for Change of Ownership only.

1. Are you changing physical locations with this change of ownership?

Yes _____ No _____ *Note: If yes, please complete Section B above*

2. Please provide date when business transaction for the change of ownership will be completed?

Date: _____

3. **Do you have a signed letter from both the buyer and seller which indicates dates the pharmacy permit license should be transferred?**

Yes _____ No _____

SECTION D. Please complete for Stock Transfer of Ownership only

1. Please provide the date when the transfer of ownership interest took place?

Date:_____

2. Did your company's FEIN change as a result of the transfer of ownership interest referenced in Section D, question 1 above?

Yes _____ No _____ *Note: If yes, please complete Section C above and include the necessary fee*

ALL QUESTIONS MUST BE ANSWERED OR YOUR APPLICATION WILL BE RETURNED

****

*Section 456.013(1), F.S., requires that applicants supplement their applications as needed to reflect any material change in any circumstances or conditions stated in the application, which takes place between the initial filing of the application and the final grant or denial of the license, which might affect the decision of the department.

I certify that the statements contained in this application are true, complete, and correct and I agree that said statements shall form the basis of my application and I do authorize the Florida Board of Pharmacy to make any investigations that they deem appropriate and to secure any additional information concerning me, and I further authorize them to furnish any information they may have or have in the future concerning me to any person, corporation, institution, association, Board, or any municipal, county, state, or federal governmental agencies or units, and I understand according to the Florida Board of Pharmacy Statutes that a Pharmacy Permit may be revoked or suspended for presenting any false, fraudulent, or forged statement, certificate, diploma, or other item, in connection with an application for a license or permit, as set forth in Section 465.015(2)(a), F.S.

Under penalty of perjury I have read the foregoing document and that the facts stated in it are true. I recognize that providing false information may result in disciplinary action against my license or criminal penalties.

SIGNATURE _____ DATE_____
(Owner or officer of establishment)

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.
Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice, Federal Bureau of Investigation,
Criminal Justice Information Services Division

Privacy Statement

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as my be relevant to the activity for which this application is being submitted, the FBI(may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law , treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Electronic Fingerprinting

Take this form with you to the Livescan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at: http://www.doh.state.fl.us/mqa/background.html;
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the Livescan service provider the Board office will not receive your background screening results;
- You must provide accurate demographic information to the livescan service provider at the time your fingerprints are taken, ***including your Social Security number (SSN)***;
- The ORI number for the Board of Pharmacy is EDOH4680Z
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name:_____ SSN#: _____ - ____ - _____

Aliases:_____

Address: _____ Apt. Number: _____

City:_____ State:_____Zip Code: _____

Date of Birth: _____/_____/_____ Place of Birth: _____
(MM/DD/YYYY)

Weight: _____ Height: _____Eye Color:_____ Hair Color: _____

Race: _____ Sex: _____
(W-White/Latino(a); B-Black; A-Asian; (M=Male; F=Female)
NA-Native American; U-Unknown)

Citizenship: _____

Transaction Control Number (TCN#):_____
(*This will be provided to you by the Livescan Service provider*.)

Keep this form for your records.

Item #1- Nuclear Prescription Department Manager Designation and Privacy Statement Acknowledgement

File #: (if known):
License #: (if

To: Florida Board of Pharmacy
Post Office Box 6320
Tallahassee, FL 32314-6320
(850) 245-4292- phone
(850) 413-6982 - fax
MQAPharmPDMAffiliate@flhealth.gov

Section A. Nuclear Prescription Department Manager

Applicant/Pharmacy Name:		
Applicant/Pharmacy Mailing Address:		
City	State	Zip
Incoming Nuclear Pharmacist Name:		License#:
		NP
Date Beginning:	Incoming Nuclear Pharmacist Signature	
PDM Transaction Control Number (TCN) – related to Livescan Fingerprints:		
Only provide following information is there is an Outgoing PDM at current pharmacy location.		
Outgoing Nuclear Pharmacist Name:		License#:
		NP
Date Ending as PDM:	Outgoing Nuclear PDM Signature	

Section B. Incoming PDM Privacy Statement Acknowledgement

Note: Acknowledgment should be completed by same person listed in Section A above as Incoming PDM.

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

Date:	Incoming Nuclear Pharmacist Signature

Item #2- Affiliate/Owner Privacy Statement Acknowledgement

To be completed by EACH Affiliate/Owner listed in the application.

To: **Florida Board of Pharmacy, Post Office Box 6320, Tallahassee, FL 32314-6320**
(850) 245-4292- phone * (850) 413-6982 – fax * MQAPharmPDMAffiliate@flhealth.gov

From:

Affiliate / Owner Name:		**File # (required):**
Applicant Name:		
Affiliate/Owner Mailing Address:		
City	**State**	**Zip**
Affiliate/Owner Email ** (see note below)	**Affiliate/Owner Telephone Number**	
Affiliate/Owner Transaction Control Number (TCN) – related to Livescan Fingerprints:		
NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.		

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

_____ _____

Affiliate/Owner Signature (Required) **Date (of signature)**

Item #3 - Policy and Procedure Questions

To be completed by Nuclear Pharmacy Applicants

Each Nuclear Pharmacy shall designate a Nuclear Pharmacist as the Prescription Department Manager who shall be responsible for compliance with all laws and regulations, both state and federal pertaining to radiopharmaceuticals and radiopharmaceutical services. A Nuclear Pharmacist must personally supervise the operation of only one Nuclear Pharmacy during all times when radiopharmaceutical services are being performed.

1) List the following:
   Firm Name:
   Doing business as (d/b/a):
   Telephone number:
   Address:
   Permit number (if already licensed as an institutional pharmacy):

2) Explain the practice setting of the proposed facility.

3) What are the objectives and purpose of the permittee? Give detailed explanation of the services of the facility scope and practice.
4) What are the experience, qualifications, special education, and/or training of the compounding pharmacist? Please provide a resume.
5) Address the ratio of supportive personnel to each pharmacist. How will the supportive personnel be utilized? Include a job description for any such supportive personnel.
6) What categories of parenteral/enteral products will be prepared (i.e. IV, enteral, irrigating, and oncology products)? Include sample labels.
7) What is the policy regarding the delivery of parenteral/enteral products to the patient? Describe methods used and trace the path the product takes from the time it leaves the permittee until it reaches the patient. Describe how products are protected from extreme temperature conditions.
8) Address the policy and procedure, special equipment and special techniques to dispense sterile preparations for parenteral therapy/nutrition. If this type of dispensing will not be performed, please state so accordingly.
9) Address the policy and procedure, special equipment and special techniques to dispense sterile jejunostomy feeding/sterile irrigation solutions. If this type of dispensing will not be performed, please state so accordingly.
10) Address the policy and procedure, special equipment and special techniques to dispense cytotoxic or anti-neoplastic agents. If this type of dispensing will not be performed, please state so accordingly.

11) What is the procedure for the annual review and updating of the policy and procedure manual?

12) Include the layout/floor plan of the pharmacy. The drawing must include the dimensions of the clean room and the pharmacy, location of the hood, sink, and other equipment. The drawing must also show the location of the clean room relative to other pharmacy and storage areas.

13) Include a sample copy of a patient profile.

14) Address the use of aseptic techniques.

15) Describe the Quality Assurance Program.

16) Describe with detail the policy and procedure for patient education, including the personnel involved.

17) Address the policy and procedure for handling waste and returns.

18) Describe the type of certified laminar flow hood(s) to be used and the frequency of certification.

19) Describe the refrigerator/freezer to be used.

20) Describe appropriate waste containers for:
    a. Used needles and syringes.
    b. Cytotoxic waste including disposable apparel used in preparation.

21) Address the following supplies to be used: gloves, mask, gowns, needles, syringes, disinfectant cleaning agents, clean towels, hand-washing materials with bactericidal properties, vacuum containers/transfer sets, and spill kits for cytotoxic agent spills.

22) Address the following references to be used:
    a. Chapters 465 and 893, F.S., and Rule 64B16, F.A.C.
    b. Authoritative Therapeutic Reference.
    c. Handbook of injectable drugs by American Society of Health-System Pharmacists.

23) Occupational Safety and Health Administration guidelines for safe handling of cytotoxic drugs.

DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF PHARMACY
4052 BALD CYPRESS WAY, BIN #C-04
TALLAHASSEE, FLORIDA 32399-3254
(850) 245-4292

SPECIAL PHARMACY PERMIT APPLICATION AND INFORMATION

January 2018

Dear Florida Pharmacy Permit Applicant,

Thank you for applying for a pharmacy permit in the State of Florida. The information in this packet has been designed to provide the essential information required to process your application in a timely manner. Your assistance in providing all required information will enable the Florida Board of Pharmacy (the Board) staff to process your application as soon as possible. You are encouraged to apply as early as possible to avoid processing delays caused by large volumes of applicants.

Florida Statutes require a completed application and fees before your application can be reviewed. Please read these instructions carefully and fully before submitting your application. You should keep a copy of the completed application and all other materials sent to the Board office for your records. When you mail the completed application and fees, use the address noted in the instructions and on the application form.

When your application arrives, your fees will be deposited and verified before the staff review can begin. You will receive a letter acknowledging receipt of your application. The staff will notify you within 30 days if any materials are incomplete.

If you need to communicate with the Board staff, you are encouraged to email the Board staff at info@floridaspharmacy.gov, or you may at call us at (850) 245-4292. Phone calls are returned within 24 hours and emails are responded to within 48 hours during normal business hours. Our staff is committed to providing prompt and reliable information to our customers. Many procedures have been streamlined to expedite the processing of applications; we certainly welcome your comments on how our services may be improved.

Sincerely,

The Board of Pharmacy

SPECIAL PHARMACY PERMIT APPLICATION INFORMATION

Whether opening a new establishment, changing locations, or changing owners, a pharmacy permit is required prior to operating in the State of Florida. The permit application must be completed and returned to the Florida Board of Pharmacy with the required fee of $255.00. The application MUST have the original signatures of the owner or officer of the establishment and the Prescription Department Manager (PDM) or Consultant Pharmacist of Record (COR). If compounding sterile preparations, the applicant must submit an additional application on Form DH-MQA 1270, "Special Sterile Compounding Permit" and pay the additional permitting fee.

Special pharmacies are pharmacies providing miscellaneous specialized pharmacy service functions. There are six (6) types of Special Pharmacy Permit applicants**. Please read the descriptions below. Check which permit type you are applying on the application.**

1. **Special Limited Community Pharmacy Permits** may be obtained by an Institutional Class II Pharmacy that dispenses medicinal drugs to employees, medical staff, emergency room patients, and other patients on continuation of a course of therapy.

2. **Special Parenteral and Enteral Pharmacy Permits** provide parenteral (IV), enteral, and cytotoxic pharmacy services to outpatients. The applicant must be compliant with the Standard for Compounding Sterile Preparations found in Rule 64B16-27.797, F.A.C. Special-Parenteral and Enteral Pharmacy Permits may stand-alone or be used in conjunction with a Community Pharmacy or Special-Closed System Pharmacy Permit. The permittee must provide 24-hour telephone accessibility.

3. **Special Closed System Pharmacy Permits** are not open to the public and prescriptions are individually prepared for dispensing utilizing closed delivery systems for ultimate consumers in health care institutions including nursing homes, jails, Assisted Living Facilities (ALF's), Intermediate Care Facility/Mentally Retarded (ICF-MR's) or other custodial care facilities when defined by Agency for Health Care Administration (AHCA) rules. This permit may not provide medications to in-patients in a hospital.

4. **Special End Stage Renal Dialysis (ESRD) Pharmacy Permits** provides dialysis products and supplies to persons with chronic kidney This permit may not provide medications to in-patients in a hospital.

5. **Special Parenteral/Enteral Extended Scope Pharmacy Permits** is required to compound patient specific enteral/parenteral preparations in conjunction with Institutional Pharmacy permits. The applicant must be compliant with the Standard for Compounding Sterile Preparations found in Rule 64B16-27.797, F.A.C.

6. **Special Assisted Living Facility (ALF) Pharmacy Permits** is an optional permit for those ALF's providing a drug delivery system utilizing medicinal drugs provided in unit dose packaging.

Pursuant to Rule 64B16-28.800, applicants for any special pharmacy permit shall provide the Board of Pharmacy with a Policy and Procedure Manual which sets for a detailed description of the type of pharmacy services to be provided within the special pharmacy practice.

Section 465.022(4), Florida Statutes, also provides that an application for a pharmacy permit must include the applicant's written policies and procedures for preventing controlled substance dispensing based on fraudulent representations or invalid practitioner-patient relationships. Pursuant to Rule 64B16-28.100(1)(e), F.A.C., The policy and procedure manual shall contain the procedures implemented to minimize the dispensing of controlled substances based on fraudulent representations as follows:

1. Provisions to identify and guard against invalid practitioner-patient relationships.
2. Provisions to guard against filling fraudulent prescriptions for controlled substances.
3. Provisions to identify prescriptions that are communicated or transmitted legally.
4. Provisions to identify the characteristics of a forged or altered prescription.

APPLICATION PROCESSING

Please read all application instructions before completing your application.

1) Please mail the application and the $255.00 application fee and fingerprint fees (check or money order made payable to the FLORIDA DEPARTMENT OF HEALTH) to the following address:

Application & Fees:
Department of Health
Board of Pharmacy
P.O. Box 6320
Tallahassee, Florida 32314-6320

Express Mail ONLY
Department of Health
Board of Pharmacy
4052 Bald Cypress Way, Bin C-04
Tallahassee, FL 32399-3254

Within 30 days of receipt of your application and fees, the board office will notify you of the receipt of your application, any required documents, and your status. If the application is complete, you will be notified that an inspector will contact you to setup an inspection appointment. Please do not contact the board office concerning your inspection date, and allow 30 days for the inspector to contact you. If the inspector has not contacted you within 30 days, then notify the board. If your application is incomplete, you will be notified in writing of what is required to make your application complete.

2) Submit fingerprint results.

Failure to submit fingerprints will delay your application. All owners, officers, and PDMs are required to submit a set of fingerprints unless the corporation is exempt under the Section 465.022, Florida Statutes, for corporations having more than $100 million of business taxable assets in this state. These corporations are only required to have the PDM to submit fingerprints. **Note: If your officer, owner, or PDM has already been fingerprinted at the time you are completing this Community Pharmacy permit application, please ensure to provide the Transaction Control Number (TCN) with the requested information in the application.**

Applicants may use any Livescan vendor that has been approved by the Florida Department of Law Enforcement to submit their fingerprints to the department. Please ensure that the Originating Agency Identification (ORI) number is provided to the vendor when you submit your fingerprints. If you do not provide an ORI number or if you provide an incorrect ORI number to the vendor, the Board of Pharmacy will not receive your fingerprint results. The applicant is fully responsible for selecting the vendor and ensuring submission of the prints to the Department.

How do I find a Livescan vendor in order to submit my fingerprints to the Department?
The Department of Health accepts electronic fingerprinting service offered by Livescan device vendors that are approved by the Florida Department of Law Enforcement and listed at their site. You can view the vendor options and contact information at:

http://www.floridahealth.gov/licensing-and-regulation/background-screening/livescan-service-providers.html

What information must I provide to the Livescan vendor I choose?

- If you are an applicant seeking a license for any profession regulated by the Department of Health, which requires a criminal background search as a condition of licensure, you must provide accurate demographic information at the time your fingerprints are taken, ***including your Social Security number***. The Department will not be able to process a submission that does not include your Social Security number.
- You must provide the correct ORI number.

Where do I get the ORI number to submit to the vendor?

- The ORI number for the pharmacy profession is **EDOH4680Z.**

Attestation for Business Taxable Assets

- If the applicant has more than $100 million dollars of business taxable assets in this state, please submit a formal opinion letter from a Certified Public Accountant duly licensed in the state of your principal place of business affirming the corporation has more than $100 million of business taxable assets in this state for the previous tax year. In lieu of submitting a formal opinion letter from a Certified Public Accountant, the applicant may submit a copy of its Florida Corporate Income/Franchise and Emergency Excise Tax Return (Form F-1120, Effective 01/09).

(3) Privacy Statement and Attestation

In order for the Board of Pharmacy Office to receive your Livescan electronic fingerprinting results, you must affirm that you have been provided with and read the attached statement from the Florida Department of Law Enforcement regarding the sharing, retention, and right to challenge incorrect criminal history records, and the "Privacy Statement" document from the Federal Bureau of Investigation. The appropriate form(s) to provide this affirmation are included within Items #1 and #2 of the application.

Licensure Process

Once the application is deemed complete, the Board staff authorizes an inspection. Upon completion of the inspection, the inspector notifies the Board office as to whether the inspection was satisfactory or unsatisfactory. If the inspection is satisfactory, a permit number is issued within 7-10 days. You will receive the actual copy of your license within 7 days. **Please wait 7-14 days from your satisfactory inspection before checking on the status of your permit with the Board office**.

You may look up your license number on our website at http://www.flhealthsource.com/ under "Verify a License."

The Board recognizes that a delay may exist between the time a pharmacy receives a Florida pharmacy permit and commences to operate. Accordingly, upon receipt of Community Pharmacy permit, a pharmacy may delay commencement of operations in compliance with the requirements provided in Rule 64B16-28.1081, F.A.C.

Drug Enforcement Administration (DEA)

Please note that the DEA will not issue a registration until the Florida Board of Pharmacy has issued a pharmacy permit. More information is available by visiting the DEA website at http://www.DEAdiversion.usdoj.gov, or by contacting them at (800)667-9752.

IMPORTANT NOTICE: Pursuant to Section 465.022(5), F.S., the Department or Board shall deny an application for a pharmacy permit if the applicant or an affiliated person, partner, officer, director, or prescription department manager or consultant pharmacist of record of the applicant:

(a) Has obtained a permit by misrepresentation or fraud.

(b) Has attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation.

(c) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy.

(d) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud.

(e) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, since July 1, 2009.

(f) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009.

(g) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period.

(h) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5-year period and the termination occurred at least 20 years before the date of the application.

(i) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

(j) Has dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466.

For felonies in which the defendant entered a plea of guilty or nolo contendere in an agreement with the court to enter a pretrial intervention or drug diversion program, the department shall deny the application if upon final resolution of the case the licensee has failed to successfully complete the program.

<u>If applicable to you, please provide the documentation to the Florida Board of Pharmacy.</u>

SPECIAL PHARMACY PERMIT APPLICATION CHECKLIST

Keep a copy of the completed application for your records.

It is recommended that you use the following checklist to help ensure that your application is complete. Failure to attach any required document, or to have required documentation sent to the Board, will result in an incomplete application. Final approval for inspection cannot be granted until the application is complete.

SPECIAL PHARMACY PERMIT

_____All Application Questions Answered, including Policy and Procedure questions located within Item #3?

_____$255.00 Fee Attached (Permit fee includes $250 application fee and $5.00 unlicensed activity fee)

_____Articles of Incorporation paperwork from the Secretary of State provided?

_____PDM Designation and Privacy Statement Acknowledgement provided (Application Item #1)?

_____Affiliate/Owner Privacy Statement Acknowledgement provided for each affiliate/owner (Application Item #2)?

_____Applicant/Affiliate/Owner supplemental documents provided for explaining any previous ownership, disciplinary actions, voluntary relinquishments and/or criminal activity?

_____Applicant/Affiliate/Owner pharmacy permit questions answered and supplemental documents provided?

_____Policies and Procedures which sets forth a detailed description of the type of pharmacy services to be provided within the special pharmacy submitted?

_____Policies and Procedures for preventing controlled substance dispensing based on fraudulent representations or invalid practitioner-patient relationships submitted?

FLORIDA BOARD OF PHARMACY
P.O. Box 6320
Tallahassee, FL 32314-6320
Telephone (850) 488-0595
http://www.floridaspharmacy.gov

SPECIAL PHARMACY PERMIT

APPLICATION

Application Type – Please choose one of the following:

___New Establishment ($255.00 fee)
Complete: Section A only, along with Items #1, #2, and #3.

___Change of Ownership ($255.00 fee)
Complete: Sections A and C only, along with Items #1 and 2.

___ Change of Location ($100.00 fee)
Complete: Sections A and B only.

___ Stock Transfer (no fee)
Complete: Section A, pages 2-3 and Section D only.

Pharmacy Permit Type – Please choose permit type(s) (fee is $255 for each permit type)

____ Special- ALF
____ Special- ESRD
_____Special- Limited Community
_____ Special- Parenteral and Enteral
____ Special- Closed System Pharmacy
____ Special- Parenteral/Enteral Extended Scope

SECTION A. Please Complete for all Application Types

Please list your Federal Employer Identification Number:

1. Corporate Name		**Telephone Number**
2. Doing Business As (d/b/a)		**E-Mail Address**** (see note below)
3. Mailing Address		
City	**State**	**Zip**
4. Physical Address		
City	**State**	**Zip**
5. List Prescription Department Manager (PDM) or Consultant Pharmacist of Record (COR)		
Name		**License Number (PS or NP)**
E-Mail Address** (see note below)		**Telephone Number**
6. Contact Person		**Title**
E-Mail Address** (see note below)		**Telephone Number**

NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

7. Special- Parenteral & Enteral Permits - ONLY
Provide 24-Hour Accessible Telephone Number Below:

(_____) _____- _____

8. Ownership Information

a. Type of Ownership: _____Individual _____Corporation _____Partnership

_____Other: _____

NOTE: IF CORPORATION OR LIMITED PARTNERSHIP YOU MUST INCLUDE WITH YOUR APPLICATION A COPY OF THE ARTICLES OF INCORPORATION ON FILE WITH THE FLORIDA SECRETARY OF STATE'S OFFICE

b. Are the applicants, officers, directors, shareholders, members and partners over the age of 18?

Yes _____ No _____

c. Does the corporation have more than $100 million of business taxable assets in this state? *If yes, provide attestation from Certified Public Accountant for previous tax year or Florida Corporate Income /Franchise and Emergency Excise Tax Return (F-1120).*

Yes _____ No _____

d. List all the owners and officers of the corporation. Each person listed below having an ownership interest of 5% or greater and any person who, directly or indirectly, manages, oversees, or controls the operation of the applicant including officers and members of the board of directors must submit a set of fingerprints and fees unless you answered yes to 8c. If 8c is "Yes", please list the owners below and only submit fingerprints for the Prescription Department Manager or Consultant Pharmacist of Record. If 8c is "Yes" and the prints are on file with DOH or AHCA and available to the Board of Pharmacy, the requirement to submit the prints for this person is met. Also, if the % of Ownership column does not add to 100%, please provide an explanation. *Attach a separate sheet if necessary.*

Owner/Officer-Title	Date of Birth	Mailing Address, City State, Zip Code	% of Ownership
	/ /		%
	/ /		%
	/ /		%
	/ /		%
	/ /		%

9. Has anyone listed in 8d. had an ownership interest of 5% or more in a pharmacy or any other business permit which was disciplined, suspended, revoked, or closed involuntarily within the past 5 years? *If yes, please provide a signed affidavit disclosing the reason the entity was closed.*

Yes _____ No _____

9a. Has anyone listed in 8d. had an ownership interest of 5% or more in a pharmacy or any other business permit which was voluntarily relinquished or closed voluntarily within the past 5 years? *If yes, please provide a signed affidavit disclosing the reason the entity was closed.*

Yes _____ No _____

Pursuant to Section 465.022(5), Florida Statutes, the following questions are being asked. If you answer "Yes" to any of the following questions, explain <u>on a separate sheet</u> providing accurate details and submit copies of supporting documentation.
10. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant obtained a permit by misrepresentation or fraud?
Yes _____ No_____
11. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation?
Yes _____ No _____
12. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy?
Yes _____ No_____
13. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud?
Yes_____ No_____
14. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, since July 1, 2009?
Yes _____ No_____
15. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009?
Yes _____ No _____
16. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period?
Yes _____ No _____
17. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5-year period and the termination occurred at least 20 years before the date of the application?
Yes _____ No _____

18. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health Human Services Office of Inspector General's List of Excluded Individuals and Entities? *(If yes, please submit proof.)*

Yes _____ No _____

19. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466?

Yes _____ No _____

20. Are you currently registered or permitted in any other states? (*If yes, provide the state, permit type, and permit number for each permit. Attach a separate sheet if necessary.)*

Yes _____ No _____

State	Permit Type	Permit Number

21. Has the applicant, affiliated person, partner, officer, directors, Prescription Department Manager or Consultant Pharmacist of Record ever owned a pharmacy? *(If yes, provide the name of the pharmacy, the state where the pharmacy is located and the status of the pharmacy. Attach a separate sheet if necessary.)*

Yes _____ No _____

Individual's Name	Pharmacy Name	State	Status

22. Has any disciplinary action ever been taken against any license, permit or registration issued to the applicant, affiliated persons, partners, officers, directors, Prescription Department Manager, or Consultant Pharmacist of Record in this state or any other?

Yes _____ No _____

23. Has the applicant, affiliated person, partner, officer, or director ever been convicted of a felony or misdemeanor, excluding minor traffic convictions? You must include all misdemeanors and felonies, even if adjudication was withheld by the court, so that you would not have a record of conviction.

Yes _____ No _____

24. Does the applicant, affiliated person, partner, officer, director have any outstanding fines, liens or overpayments assessed by a final order of the department? If yes please answer 24a.

Yes _____ No _____

24a. Does the applicant, affiliated person, partner, officer, director have a repayment plan approved by the department?
Yes _____ No_____

SECTION B. Please complete for Change of Location only.

1. Current Practice Location Address		
City	**State**	**Zip**

E-Mail Address** (see note below)	**Telephone Number**

2. New Practice Location Address		
City	**State**	**Zip**

E-Mail Address** (see note below)	**Telephone Number**

Please provide your existing Pharmacy Permit Number(s):

Please provide your existing Federal DEA Number:

NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

SECTION C. Please complete for a Change of Ownership only.

1. Are you changing physical locations with this change of ownership?

Yes _____ No _____ *NOTE: If yes, please complete Section B above.*

2. Please provide date when business transaction for the change of ownership will be completed?

Date: _____

3. Do you have a signed letter from both the buyer and seller which indicates dates that pharmacy permit license should be transferred? *Note: A copy of the signed letter should be provided with your application.*

Yes _____ No _____

SECTION D. Please complete for a Stock Transfer of Ownership only.

1. Please provide the date the transfer of ownership interest took place?

Date: _____

2. Did your company's FEIN change as a result of the transfer of ownership interest referenced in Section D, question 1 above?

Yes _____ No _____ *NOTE: If yes, please complete Section C above and include the necessary fee.*

ALL QUESTIONS MUST BE ANSWERED OR YOUR APPLICATION WILL BE RETURNED

****

Section 456.013(1), F.S., requires that applicants supplement their applications as needed to reflect any material change in any circumstances or conditions stated in the application, which takes place between the initial filing of the application and the final grant or denial of the license, which might affect the decision of the department.

I swear or affirm that the statements contained in this application are true, complete, and correct and I agree that said statements shall form the basis of my application and I do authorize the Florida Board of Pharmacy to make any investigations that they deem appropriate and to secure any additional information concerning me, and I further authorize them to furnish any information they may have or have in the future concerning me to any person, corporation, institution, association, Board, or any municipal, county, state, or federal governmental agencies or units, and I understand according to the Florida Board of Pharmacy Statutes that a Pharmacy Permit may be revoked or suspended for presenting any false, fraudulent, or forged statement, certificate, diploma, or other item, in connection with an application for a license or permit, as set forth in Section 465.015(2)(a), F.S.

Under penalty of perjury I have read the foregoing document and that the facts stated in it are true. I recognize that providing false information may result in disciplinary action against my license or criminal penalties.

SIGNATURE _____ DATE_____
(Owner or officer of establishment)

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.
Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice, Federal Bureau of Investigation,
Criminal Justice Information Services Division

Privacy Statement

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as my be relevant to the activity for which this application is being submitted, the FBI(may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law , treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Electronic Fingerprinting

Take this form with you to the Live Scan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at: http://www.doh.state.fl.us/mqa/background.html;
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the livescan service provider the Board office will not receive your background screening results;
- You must provide accurate demographic information to the livescan service provider at the time your fingerprints are taken, ***including your Social Security number (SSN)***;
- The ORI number for the Board of Pharmacy is **EDOH4680Z**.
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name:_____ SSN#: _____ - ____ - _____

Aliases: _____

Address: _____Apt. Number: _____

City:_____ State_____Zip Code: _____

Date of Birth: _____/_____/_____ Place of Birth: _____
(MM/DD/YYYY)

Weight: _____ Height: _____ Eye Color:_____ Hair Color: _____

Race: _____ Sex: _____
(W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown) (M=Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#):_____
(*This will be provided to you by the Livescan Service provider*.)

Keep this form for your records.

Item #1- Prescription Department Manager (PDM) or Consultant Pharmacist of Record (COR) Privacy Statement Acknowledgement

File # (if known):	License # (if applicable):

To: Florida Board of Pharmacy, Post Office Box 6320, Tallahassee, FL 32314-6320
(850) 245-4292- phone * (850) 413-6982 – fax * MQAPharmPDMAffiliate@flhealth.gov

Section A. Prescription Department Manager (PDM) or Consultant Pharmacist of Record (COR) Designation

Applicant/Pharmacy Name:		
Applicant/Pharmacy Mailing Address:		
City	**State**	**Zip**
Incoming PDM / COR Name:		**License#:**
Date Beginning as PDM / COR:	**Incoming PDM / COR Signature**	
PDM / COR Transaction Control Number (TCN) – related to Livescan Fingerprints:		
*****Only provide following information is there is an Outgoing PDM or COR at current pharmacy location.*****		
Outgoing PDM / COR Name:		**License#:**
Date Ending as PDM / COR:		

Section B. Incoming PDM / COR Privacy Statement Acknowledgement

Note: Acknowledgment should be completed by same person listed in Section A above as Incoming PDM or COR.

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

Date:	Incoming PDM / COR Signature

Item #2- Affiliate/Owner Privacy Statement Acknowledgement

To be completed by EACH Affiliate/Owner listed in the application.

To: **Florida Board of Pharmacy, Post Office Box 6320, Tallahassee, FL 32314-6320**
(850) 245-4292- phone * (850) 413-6982 – fax * MQAPharmPDMAffiliate@flhealth.gov

From:

Affiliate / Owner Name:		**File # (required):**
Applicant Name:		
Affiliate/Owner Mailing Address:		
City	**State**	**Zip**
Affiliate/Owner Email ** (see note below)	**Affiliate/Owner Telephone Number**	
Affiliate/Owner Transaction Control Number (TCN) – related to Livescan		
NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.		

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

_____ _____

Affiliate/Owner Signature (Required) **Date (of signature)**

Item #3 - Policy and Procedure Questions

Special-Parenteral and Enteral and Special-Parenteral/Enteral Extended Scope Applicants Complete the Following Questions.

The Consultant Pharmacist of Record is responsible for developing and maintaining a current policy and procedure manual. A copy of the permittee's policy and procedure manual as provided herein shall accompany the permit application. The original policy and procedure manual shall be kept within the pharmacy and shall be available for inspection by the Department of Health. The Board office will approve the policy and procedure manual based upon answers submitted for the following questions, where applicable, by using excerpts or summaries from the policy and procedure manual.

1) List the following:
   Firm Name:
   Doing business as (d/b/a):
   Telephone number:
   Address:
   Permit number (if already licensed as an institutional pharmacy):

2) Explain the practice setting of the proposed facility.

3) What are the objectives and purpose of the permittee? Give detailed explanation of the services of the facility scope and practice.

4) What are the experience, qualifications, special education, and/or training of the compounding pharmacist? Please provide a resume.

5) Address the ratio of supportive personnel to each pharmacist. How will the supportive personnel be utilized? Include a job description for any such supportive personnel.

6) What categories of parenteral/enteral products will be prepared (i.e. IV, enteral, irrigating, and oncology products)? Include sample labels.

7) What is the policy regarding the delivery of parenteral/enteral products to the patient? Describe methods used and trace the path the product takes from the time it leaves the permittee until it reaches the patient. Describe how products are protected from extreme temperature conditions.

8) Address the policy and procedure, special equipment and special techniques to dispense sterile preparations for parenteral therapy/nutrition. If this type of dispensing will not be performed, please state so accordingly.

9) Address the policy and procedure, special equipment and special techniques to dispense sterile jejunostomy feeding/sterile irrigation solutions. If this type of dispensing will not be performed, please state so accordingly.

10) Address the policy and procedure, special equipment and special techniques to dispense cytotoxic or anti-neoplastic agents. If this type of dispensing will not be performed, please state so accordingly.

11) What is the procedure for the annual review and updating of the policy and procedure manual?

12) Include the layout/floor plan of the pharmacy. The drawing must include the dimensions of the clean room and the pharmacy, location of the hood, sink, and other equipment. The drawing must also show the location of the clean room relative to other pharmacy and storage areas.

13) Include a sample copy of a patient profile.

14) Address the use of aseptic techniques.

15) Describe the Quality Assurance Program.

16) Describe with detail the policy and procedure for patient education, including the personnel involved.

17) Address the policy and procedure for handling waste and returns.

18) Describe the type of certified laminar flow hood(s) to be used and the frequency of certification.

19) Describe the refrigerator/freezer to be used.

20) Describe appropriate waste containers for:

    a. Used needles and syringes.

    b. Cytotoxic waste including disposable apparel used in preparation.

21) Address the following supplies to be used: gloves, mask, gowns, needles, syringes, disinfectant cleaning agents, clean towels, hand-washing materials with bactericidal properties, vacuum containers/transfer sets, and spill kits for cytotoxic agent spills.

22) Address the following references to be used:

    a. Chapters 465 and 893, F.S., and Rule Title 64B16, F.A.C.

    b. Authoritative Therapeutic Reference.

    c. Handbook of Injectable Drugs by American Society of Health-System Pharmacists.

23) Occupational Safety and Health Administration guidelines for safe handling of cytotoxic drugs.

If applying for a Special- Parenteral/Enteral Extended Scope Permit, answer the additional questions below:

24) Describe the individual responsibilities of the Special- Parenteral/Enteral Extended Scope Permit and the supplied institutional pharmacy permits, if applicable.

25) Address the maintenance of patient profiles and the offer to counsel if dispensing to outpatients.

26) Describe the system for the maintenance of compounding records.

Prescription Department Manager (PDM)
Designation and Privacy Statement Acknowledgement

Section 465.022(11), Florida Statutes, requires the permittee and newly designated Prescription Department Manager to notify the Board of Pharmacy within ten (10) days of any change.

Pursuant to section 465.022(11), a Prescription Department Manger is responsible for maintaining all drug records, providing for the security of the prescription department and following such other rules as relate to the practice of the profession of pharmacy.

File #: (if known)	**License#:** (required)
_ _ _ _ _	**PH**

Section A. Prescription Department Manager (PDM) Designation

Applicant/Pharmacy Name:		
Applicant/Pharmacy Mailing Address:		
City	**State**	**Zip**
Incoming PDM Name:		**License#:**
		PS
Date Beginning as PDM:	**Incoming PDM Signature**	
PDM Transaction Control Number (TCN) – related to Livescan Fingerprints:		
****OPTIONAL: Only provide following information if there is an Outgoing PDM at current pharmacy****		
Outgoing PDM Name:		**License#:**
		PS
Date Ending as COR:	**Outgoing PDM Signature**	

Section B. Incoming PDM Privacy Statement Acknowledgement

Note: Acknowledgment should be completed by same person listed in Section A above as Incoming PDM.

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

Date:	**Incoming PDM Signature**

SEND TO: Florida Board of Pharmacy, Post Office Box 6320, Tallahassee, FL 32314-6320
(850) 245-4292 (phone) * (850) 413-6982 (fax) * *MQAPharmPDMAffiliate@flhealth.gov* - email

Consultant Pharmacist of Record (COR)
Designation and Privacy Statement Acknowledgement

Section 465.022, Florida Statutes, requires the permittee and newly designated Prescription Department Manager to notify the Board of Pharmacy within ten (10) days of any change.

Rule 64B16-28.501, Florida Administrative Code, requires each facility holding a Class I, Class II, or a Modified Class II Institutional Pharmacy Permit to designate a Consultant Pharmacist of Record (COR) to ensure compliance with the laws and rules governing the permit. The Board Office shall be notified in writing within ten (10) days of any change in the COR.

File #: (if known)	**License#:** (required)
_ _ _ _ _	**PH**

Section A. Consultant Pharmacist of Record (COR) Designation

Applicant/Pharmacy Name:		
Applicant/Pharmacy Mailing Address:		
City	**State**	**Zip**
Incoming COR Name:		**License#:**
		PU
Date Beginning as COR:	**Incoming COR Signature**	
COR Transaction Control Number (TCN) – related to Livescan Fingerprints:		
****OPTIONAL: Only provide following information if there is an Outgoing COR at current pharmacy****		
Outgoing COR Name:		**License#:**
		PU
Date Ending as COR:	**Outgoing COR Signature**	

Section B. Incoming COR Privacy Statement Acknowledgement

Note: Acknowledgment should be completed by same person listed in Section A above as Incoming COR.

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

Date:	**Incoming COR Signature**

SEND TO: Florida Board of Pharmacy, Post Office Box 6320, Tallahassee, FL 32314-6320
(850) 245-4292 (phone) * (850) 413-6982 (fax) * *MQAPharmPDMAffiliate@flhealth.gov* - email