PENNSYLVANIA STATE BOARD OF PHARMACY

(717) 783-7156 www.dos.pa.gov/pharm st-pharmacy@pa.gov

Mailing Address: (USPS)
PO Box 2649
Harrisburg, PA 17105-2649

Courier Address: (UPS, FED-EX, etc.)
PA Dept of State, Bureau of Professional and Occupational Affairs
Attn: State Board of Pharmacy
2 Technology Park
Harrisburg, PA 17110-2919

PHARMACY APPLICATION (# 854 107B, Rev. 9/19)

Type of Transaction Requested (Check One)

( ) Change in Ownership…….. $30.00 Fee
( ) Change in Controlling Interest…….$30.00 Fee

Make fee payable to the "Commonwealth of PA." Fees are not refundable. Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

Name/title of pharmacy:_____

Pharmacy permit number:_____

Contact person's name and phone number:_____

Contact person's e-mail address:_____

Contact person's address:_____

_____

The Pennsylvania State Board of Pharmacy (Board) will request submission of a new application along with the required application fee if any discrepancies with this application have not been appropriately addressed within one year of the original date of application submission. The pharmacy permit may also be subject to disciplinary action for a violation of Board Regulation Section 27.11(d) if a properly completed application is not submitted to the Board office within 30 days of the change ownership or controlling interest.

The Board has the following policy regarding change in ownership/controlling interest of an established pharmacy. The new owner will be responsible for the operation and practice of pharmacy in accordance with the Pharmacy Act and Board Regulations. Once the application is processed, the Board will notify the following agencies of the change: DEA, PACE, Department of Public Welfare, Department of Health, and NCPDP.

*****The permit number will NOT change with the processing of this application*****

Please complete the following sections with regard to ownership of this pharmacy.

Full name of the pharmacy's owner:_____

The owner is a (check one):

( ) Corporation - List the names of the director and principal officers, the offices they hold, their home addresses and the percentage of stock owned *in the spaces below*.
( ) Limited Liability Company (LLC) - List the officers/members, the offices they hold (if any), their home addresses and the percentage of interest owned *in the spaces below*.
( ) Hospital - List the name of the hospital administrator and their home address along with the names of the hospital's principal officers, the offices they hold, their home addresses, and the percentage of interest owned *in the spaces below*.
( ) Nursing Home - List the name of the nursing home administrator and their home address along with the names of the nursing home's principal officers, the offices they hold, their home addresses, and the percentage of interest owned *in the spaces below*.
( ) Individual(s) - List the name(s) of the individual owner(s), their pharmacist license number(s) (if any), their home addresses, and the percentage of ownership *in the spaces below*.
( ) Limited Partnership - List the names of the principal officers (if any) and the names of the individuals overseeing the operation of the limited partnership, the offices they hold (if any), their home addresses and the percentage of interest owned *in the spaces below*.
( ) Other (specify)_____ - List the names of the director and the principal officers, the offices they hold, their home addresses and the percentage of interest owned *in the spaces below*.

<u>Complete</u> this section as directed above (names, titles, home addresses, % stock/interest):

_____
_____
_____
_____
_____
_____
_____

Names of **<u>stock/interest holders</u>** with more than 10% Home address Percentage of stock/interest

_____
_____
_____
_____

Does a medical practitioner have any proprietary interest in the pharmacy? ( ) Yes ( ) No
If "Yes", indicate the percentage of interest:_____%
If "Yes", please provide information regarding the involvement of the medical practitioner in the direction, control and daily operation of the pharmacy.

Are there any pending indictments of any nature or any alleged violations of the law governing the practice of pharmacy against any of the individuals listed on this application or have any of them been convicted of any crimes within the past ten years? ( ) Yes ( ) No
If yes, please give details on an attached sheet of paper.

VERIFICATION

I verify that this application is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information under 18 Pa.C.S. § 4911.

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa.C.S. § 4904 (relating to unsworn falsification to authorities) and may result in the suspension, revocation or denial of my license, certificate, permit or registration.

The prescription area of this pharmacy has all of the equipment and facilities that are required in the Pharmacy Act and Board Regulations and in the event of loss or breakage of any item on the equipment list, it will be replaced immediately.

I agree to display the pharmacy permit conspicuously and I understand that the pharmacy permit may not be transferred.

I agree to notify the Board immediately in the event that I should change location, change ownership, change title, change pharmacist manager, remodel or discontinue this pharmacy. I agree to notify the Board in the event of a fire or flood or if the pharmacy permit has been lost or misplaced.

I agree, as a non-pharmacist owner, not to exercise control over the professional activities of the licensed pharmacists under my employ. I will not be involved in any pharmacy-related activity which requires the professional judgment of a licensed pharmacist.

_____ _____
Signature of the Registered Pharmacist Manager Date

_____
Printed Name of Registered Pharmacist Manager

License Number:__RP-_____

AND _____ _____
Signature of the Owner's Authorized Representative Date

Title:_____

Printed Name:_____

CHANGE OF OWNERSHIP VERIFICATION
(For change in ownership ONLY)

_____, current/former owner(s)
(Name of the Current Owner)

of an established pharmacy operating under the title of_____,

with permit # _____, do hereby certify that a purchase agreement

was/will be signed on _____with_____
(Month/Day/Year) (Name of New Owner(s))

and that the actual ownership transfer date is _____.
(Month/Day/Year)

Signature_____
(Former Owner(s) or Registered Agent of Former Owner)

Signature_____
(New Owner(s) or Registered Agent of New Owner)

Please provide the new Federal Employer Identification

No. (FEIN):_____

CHANGE OF CONTROLLING INTEREST VERIFICATION
(For change in controlling interest ONLY)

As the authorized representative of the owner listed at the top of page two of this application,

with regard to the established pharmacy operating under the title of

_____ with permit #_____,

I do hereby certify that controlling interest changed as of _____and as
(Month/Day/Year)

indicated on page 2 of this application.

Signature_____
(Owner or Registered Agent of Owner)

If applicable, please provide the new Federal Employer Identification

No. (FEIN):_____

Helpful Information

Before submitting your application, please refer to the following helpful hints.

Page One:

1. Have you marked the correct transaction? Only one transaction should be chosen.
2. Are you submitting the correct application fee?

Page Two:

1. Have you provided the name of the new owner for a change in ownership or the name of the current owner for a change in controlling interest? If an entity such as a corporation or limited liability company (LLC) directly owns the pharmacy permit, provide the corporation's or the LLC's name here – do not list the stockholders or members. Stockholder/officer/member information will be provided in another section on application page two.
2. Have you indicated the type of ownership?
3. Have you provided the director/officer/member information that was requested?
4. Have you provided **home** addresses, where requested?
5. Have you provided the percentage of stock/interest owned or held by the individuals who are listed on this page? "Zero" is an acceptable number, if accurate.
6. Have you answered both questions located near the bottom of the page and provided any additional information as directed?

Page Three:

1. Has the pharmacy's registered pharmacist manager signed and dated the form? Has the pharmacist manager provided his/her printed name and license number?
Note: You **cannot** change pharmacist managers using this application. When a pharmacy has had a change in pharmacist manager, the "Application for Change in Pharmacist Manager Within an Established Pharmacy" and the application fee must be submitted.
2. Has the authorized representative of the pharmacy's owner signed and dated the form as well as provided his/her title and printed name?

Page Four:

1. For a change in ownership, have you completed the top portion of this page? For a change in controlling interest, have you completed the bottom portion of this page? Do **not** complete both sections.
2. Have you provided the correct name of the owner? The pharmacy permit owner's name should be provided, not the names of the stockholders/interest holders.
3. Are the pharmacy's name and permit number correct?
4. Have the dates been provided in month/day/year format?
5. Have the authorized representative(s) signed ?
6. If applicable, was the new FEIN provided?