



# STATE OF MAINE BOARD OF PHARMACY

**Applicant information to assist  
in completing your application**

**Mail Order Pharmacy**

**Do not return the following informational pages with your  
application; it is for your information only**

Department of Professional and Financial Regulation  
Office of Licensing and Registration  
(Mailing address) 35 State House Station, Augusta, ME 04333  
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

Office Direct Line (207) 624-8620 or Main Receptionist (207) 624-8603  
TTY/Hearing Impaired 1-888-577-6690  
FAX (207) 624-8637

Web address: [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing)  
Email: [pharmacy.lic@maine.gov](mailto:pharmacy.lic@maine.gov)

## **APPLICATION INSTRUCTIONS** **MAIL ORDER PHARMACY LICENSE**

The following documentation must be submitted with your original application for licensure. Failure to provide any information requested will result in the return of your application and subsequently delay the processing of your application. This checklist is designed to assist with your application process. It does not, however, replace the requirements outlined in the Board of Pharmacy Laws and Rules. Please review them carefully for more detailed and clarifying information.

- Completed application with the appropriate fee.
- Most recent inspection report from the state in which this facility is located.
- Any other supporting documentation such as: verification of licensure or criminal conviction information.

Submit verification from every state in which this entity currently hold or have ever held any type of professional license (except Maine).

Court judgment and decision of any criminal conviction and a written statement regarding the crime.

- NPDB/HIPDB Self Query Report - **What is a NPDB/HIPDB Self Query?**

NPDB/HIPDB is the National Practitioners Data Bank (“NPDB”) and Healthcare Integrity and Protection Data Bank (“HIPDB”). They are national data collection programs for the reporting and disclosing of certain final adverse actions taken against health care practitioners. Information regarding licensure actions, exclusions from participation in Federal and State health care programs, healthcare-related criminal convictions and civil judgments, and other adjudicated actions or decisions is collected as well.

In accordance with 10 MRS §8003(10), all applicants must submit a NPDB/HIPDB Self-Query Report as part of the initial application for licensure. The instructions to request a self-query report are available at NPDB/HIPDB’s website: [www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov). The website includes a Fact Sheet on self-querying, as well as FAQs to assist you in requesting a report.

Following directions on the website, you will download and print out the Individual Self-Query form. You must sign and notarize this form as directed on the form and mail it to the address provided on the form. In about 3-5 days you should receive the results of the database search from Data Bank. It is your responsibility to attach the original of each the NPDB and the HIPDB report to your application. The NPDB and the HIPDB are two separate reports, be sure you check the top of each report; it should say NPDB RESPONSE TO SELF-QUERY and HIPDB RESPONSE TO SELF-QUERY.

***If you applying for a company/business type license, you only need to do the HIPDB Self-Query.***

Our office cannot assist you with the Self-Query process. Customer Service Contact information: NPDB-HIPDB Customer Service Center - Tel: (800)767-6732 - TDD: (703)802-9395

## **PROCESSING TIME:**

- ✓ Please allow approximately three (3) weeks processing time from date of receipt.
- ✓ Please do not call our office regarding the status of your application as numerous calls will delay the timeliness of processing applications. Information regarding the status of applications may be found at the Office of Licensing and Registration's website [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing). We appreciate your thoughtful attention to this request.
- ✓ Once your license is issued it is immediately visible online with an "active" status. Licenses are printed off site and require at least 14 days for delivery.

**INITIAL EACH PAGE OF YOUR APPLICATION WHERE NOTED.** Be sure to initial the bottom of each page where noted on your application. This is critical to insuring that each page of your application is intact with the correlating application and will help us with expediting your application review.

The Board of Pharmacy requires that all supporting documents and fees be submitted with the filing of your application. **Your application will be considered incomplete and will be returned if the application is not fully completed or supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

## **VERIFICATION OF LICENSURE IN ANOTHER STATE OR JURISDICTION**

If you hold or have held a pharmacy license in another state or jurisdiction, you must submit evidence from the State of licensure in the form of a License Verification.

Please contact the state of licensure to request an official License Verification. At a minimum, the license verification must contain:

- Name of State providing the License Verification
- Your name
- License number and expiration date
- Type of license issued to you
- Status of your license i.e. active, inactive, lapsed, probation, restricted, suspended, revoked...
- Date your license was issued
- Last date of inspection.
- Disciplinary action(s) against your license, if any
- Signature and title of person from the licensing jurisdiction providing License Verification
- State Seal

**Please direct the licensing jurisdiction to send the License Verification report to you directly and in turn you must submit this verification with your completed Maine application.**

### Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 AM to 5:00 PM weekdays
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be mailed to you.
- **How long does it take to process an application?** You can check our website: [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing). Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.

### NOTICES

**BACKGROUND CHECK:** Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Licensing and Registration requires a criminal history records check as part of the application process for all applicants.

**PUBLIC RECORD:** This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

**SOCIAL SECURITY NUMBER:** The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(1)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36

#### Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the criminal background disclosure questions
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) or credit card information (plus signature)
- Include any required transcripts or exam results
- Make a copy of your application to keep for your records
- DO NOT SEND CASH.



**STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
OFFICE OF LICENSING AND REGISTRATION  
COMPANY APPLICATION**

<b>APPLICANT INFORMATION (please print)</b>			
NAME OF MAIL ORDER PHARMACY			
FEIN OR SSN			
PHYSICAL LOCATION			
CITY	STATE	ZIP	COUNTY
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # (    )		FAX # (    )	
PERSON RESPONSIBLE FOR COMPLETING AND SUBMITTING APPLICATION			
By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Licensing and Registration will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.			
<b>SIGNATURE</b>		<b>DATE</b>	

**Board of Pharmacy  
Mail Order Pharmacy  
Required Fee: \$200.00**

*Office Use Only:*  
  
MO1421 - \$200.00

*Office Use Only:*

Check # \_\_\_\_\_  
Amount: \_\_\_\_\_  
Cash # \_\_\_\_\_  
Lic. # \_\_\_\_\_  
Issue Date \_\_\_\_\_  
Exp. Date \_\_\_\_\_

<b>PAYMENT OPTIONS:</b>			
Make checks payable to "Maine State Treasurer" - If you wish to pay by Mastercard or Visa, fill out the following:			
NAME OF CARDHOLDER (please print)	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
I authorize the Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my			
<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	the following amount: \$ _____	
Card number:	<i>XXXX-XXXX-XXXX-XXXX</i>	Expiration Date	<i>mm / yyyy</i>
<b>SIGNATURE</b>		<b>DATE</b>	

**SECTION 1: TYPE OF APPLICATION**

- Initial Application     Change of Ownership     Change of Location     PIC Change

Previous License Number: \_\_\_\_\_

**SECTION 2: CONTACT INFORMATION** *(person responsible for completing and submission of application must be an owner or officer of the entity).*

Last Name	First Name	Middle Name	
Contact Address	City	State	Zip Code
Telephone Number	E-mail Address		
(    )			

**SECTION 3: MAIL ORDER PHARMACY DETAIL INFORMATION**

Name of Mail Order Pharmacy	
Mail Order Pharmacy Telephone Number	Mail Order Pharmacy Fax Number
(    )	(    )
24 - Hour Telephone Number	
(    )	
E-mail Address	Web Address
DEA #	Date Executed
FDA #	Date Executed
All Trade Names or Business Names of the Mail Order Pharmacy	

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INITIALS OF APPLICANT

**SECTION 4: PHARMACIST IN CHARGE INFORMATION**

Last Name	First Name	Middle Name
Contact Address	City	State, Zip Code
Telephone Number	E-mail Address	
(    )		
License Number:	State Issued	

**SECTION 5: TYPE OF FACILITY**

Please check all that apply to this mail order pharmacy. This facility is a:

- |   |  |
|---|--|
| <input type="checkbox"/> Retail Chain                     | <input type="checkbox"/> Retail Independant      |
| <input type="checkbox"/> Nuclear Pharmacy                 | <input type="checkbox"/> Long Term Care Pharmacy |
| <input type="checkbox"/> Opiate Treatment Program/ Center | <input type="checkbox"/> Automated Dispensing    |
| <input type="checkbox"/> Central Fill Pharmacy            | <input type="checkbox"/> Central Fill Processing |
| <input type="checkbox"/> Other: _____                     | <input type="checkbox"/> Other: _____            |

**SECTION 6: COMPETE THIS SECTION ONLY IF YOU ARE USING A CENTRAL FILL PROCESSING OR CENTRAL FILL PHARMACY**

<p>Is this pharmacy under the same ownership of the central fill processing or the central fill pharmacy?</p> <p>If no, Board Rules, Chapter 21, section 3 requires a central fill pharmacy and/ or central processing center that processes, fills or refills a prescription drug order to have a contract with or have the same owner as the retail pharmacy or other health care facility identified in Section 1(1) of this chapter from which it received the prescription drug order. The contract must include provisions that protect the confidentiality of patient information. Please attach a copy of the contract.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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INITIALS OF APPLICANT

**SECTION 7: OWNERSHIP.** Please check one and complete the appropriate block below.

- Sole Proprietor (*complete section A*)
- Partnership (*complete section B*)
- Corporation (*complete section C*)

<b>Section A - Sole Proprietor:</b> (Please type or print legibly)			
Owner Last Name		First Name	Middle Name
Social Security Number		Name of Business Entity	
Name of Business Entity			
Contact Address		City	State
Address of Principle Office Location		City	State
Telephone Number		Fax Number	
(    )		(    )	
E-mail Address		Website Address	
Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):			

<b>Section B - Partnership:</b> List all name and addresses of all partners (please type or print legibly). <i>Please see Chapter 8, Sec. 1(4)(A) (If you need more space please use separate sheet)</i>			
1. Last Name	First Name		Middle Name
Address	City		State
Telephone Number		Social Security Number or FEIN Number	
(    )			
E-mail Address			
Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):			

INITIALS OF APPLICANT

**SECTION 7-B (Continued): PARTNERSHIP OWNERSHIP**

2. Last Name		First Name		Middle Name	
Address		City		State	Zip Code
Telephone Number			Social Security Number or FEIN Number		
(     )					
E-mail Address					
Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):					

3. Last Name		First Name		Middle Name	
Address		City		State	Zip Code
Telephone Number			Social Security Number or FEIN Number		
(     )					
E-mail Address					
Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):					

4. Last Name		First Name		Middle Name	
Address		City		State	Zip Code
Telephone Number			Social Security Number or FEIN Number		
(     )					
E-mail Address					
Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):					

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INITIALS OF APPLICANT

**SECTION 7 (Continued): OWNERSHIP**

<b>Section C - Corporation Ownership:</b> (Please type or print legibly) <i>Please see Chapter 8, Sec. 1(4)(B)</i>			
Name of Corporation			
Assumed Name (d/b/a)			
Name of Parent Company, if any			
FEIN #			
Contact Address of Corporation	City	State	Zip Code
Physical Address of Corporation	City	State	Zip Code
Telephone Number	Fax Number		
(      )			
E-mail Address	Website Address		
Corporate Registration Certificate Number	Issued Under What Jurisdiction	Date	

**A Certificate of Existence from the State of origin, Corporations Office MUST accompany this application. For Corporations not organized under Maine law, a Certificate of Authority from the Maine Secretary of State is required. For assistance, call (207) 624-7752.**

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INITIALS OF APPLICANT

**SECTION 7-C (Continued): CORPORATION OWNERSHIP**

**Please see Chapter 8, Section 1(4)(B). List the name and contact address of each shareholder owning 10% or more of the voting stock of the corporation, including over-the-counter stock, unless the stock is traded on a major stock exchange and not over-the-counter. Use a separate sheet of paper if needed.**

1. Last Name	First Name	Middle Name	
Address	City	State	Zip Code
Telephone Number	Social Security Number or FEIN Number		
(     )			
E-mail Address			
Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):			

2. Last Name	First Name	Middle Name	
Address	City	State	Zip Code
Telephone Number	Social Security Number or FEIN Number		
(     )			
E-mail Address			
Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):			

\_\_\_\_\_  
INITIALS OF APPLICANT

**SECTION 7-C (Continued): CORPORATION OWNERSHIP**

3. Last Name	First Name	Middle Name	
Address	City	State	Zip Code
Telephone Number	Social Security Number or FEIN Number		
(     )			
E-mail Address			
Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):			

4. Last Name	First Name	Middle Name	
Address	City	State	Zip Code
Telephone Number	Social Security Number or FEIN Number		
(     )			
E-mail Address			
Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):			

5. Last Name	First Name	Middle Name	
Address	City	State	Zip Code
Telephone Number	Social Security Number or FEIN Number		
(     )			
E-mail Address			
Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):			

\_\_\_\_\_  
INITIALS OF APPLICANT

**SECTION 7-C (Continued): CORPORATION OWNERSHIP**

6. Last Name		First Name		Middle Name	
Address		City		State	
Telephone Number			Social Security Number or FEIN Number		
(     )					
E-mail Address					
Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):					

7. Last Name		First Name		Middle Name	
Address		City		State	
Telephone Number			Social Security Number or FEIN Number		
(     )					
E-mail Address					
Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):					

8. Last Name		First Name		Middle Name	
Address		City		State	
Telephone Number			Social Security Number or FEIN Number		
(     )					
E-mail Address					
Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):					

\_\_\_\_\_  
INITIALS OF APPLICANT

**SECTION 7-C (Continued): CORPORATION OWNERSHIP**

9. Last Name		First Name		Middle Name
Address		City	State	Zip Code
Telephone Number			Social Security Number or FEIN Number	
(     )				
E-mail Address				
<p>Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No</p> <p>If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):</p>				

10. Last Name		First Name		Middle Name
Address		City	State	Zip Code
Telephone Number			Social Security Number or FEIN Number	
(     )				
E-mail Address				
<p>Is this individual licensed, registered, or otherwise authorized in any jurisdiction to prescribe drugs? ___Yes ___No</p> <p>If yes, list license type(s), license # and expiration date, and licensing jurisdiction(s):</p>				

\_\_\_\_\_  
INITIALS OF APPLICANT

**SECTION 8: THIS SECTION TO BE COMPLETED BY THE MAIL ORDER PHARMACY OWNER OR OFFICER**

<p>Have you or has any corporate officers, owners, or the designated officer of this entity been indicted, arrested or convicted of any criminal offense (including motor vehicle criminal offenses)? If yes:</p> <ol style="list-style-type: none"> <li>1. Provide a <u>detailed explanation</u> in the offender's own words on a separate sheet of paper.</li> <li>2. Attach a copy of the <u>Court Judgment and Decision</u>.</li> <li>3. If a motor vehicle criminal offense, attach a copy of a recent motor vehicle report.</li> </ol>	<input type="checkbox"/> Yes  <input type="checkbox"/> No
<p>Has <u>this entity</u> ever been notified by the regulatory jurisdiction of any state or province of Canada of the existence of allegations, filed with or by that jurisdiction, which were not dismissed by a finding of that jurisdiction that the allegations were without merit? (Note: Accusations which remain open as of the date of this application and which are not confidential by law require a <b>YES</b> response and explanation.) If yes:</p> <ol style="list-style-type: none"> <li>1. List the jurisdiction(s):            State/Jurisdiction _____ Date _____            State/Jurisdiction _____ Date _____</li> <li>2. Provide a detailed explanation in your own words on a separate sheet of paper.</li> </ol>	<input type="checkbox"/> Yes  <input type="checkbox"/> No
<p>Has any state or territory of the U.S., province/territory of Canada, or any other jurisdiction EVER denied your application for any type of examination, professional license, certificate or registration, or taken any disciplinary action against the license issued to you in that jurisdiction (including, but not limited to, warning, reprimand, fine, suspension, revocation or restrictions in permitted practice, probation with or without monitoring)? If yes:</p> <ol style="list-style-type: none"> <li>1. List the jurisdiction(s) that denied your license or issued discipline and date of action:            State/Jurisdiction _____ Date _____            State/Jurisdiction _____ Date _____</li> <li>2. Submit a copy of the consent agreement or decision and order for each of the above.</li> <li>3. Provide a detailed explanation in your own words on a separate sheet of paper.</li> </ol>	<input type="checkbox"/> Yes  <input type="checkbox"/> No
<p>Have any corporate officer or anyone listed on this application as having an ownership interest in this entity ever been disciplined by a professional society? If yes:</p> <ol style="list-style-type: none"> <li>1. Name of the professional society or organization and date of action.             Name _____            Address _____             Date of Action _____</li> <li>2. Submit a copy of the official action taken.</li> <li>3. Provide a detailed explanation in your own words on a separate sheet of paper.</li> </ol>	<input type="checkbox"/> Yes  <input type="checkbox"/> No
<p>Have any corporate officers or anyone listed on this application as having an ownership interest in this entity ever been notified by any state or territory of the U.S., province/ territory of Canada, or any other jurisdiction of the existence of allegations, filed with or by that jurisdiction, against which were not dismissed by a finding of that jurisdiction that the allegations wer without merit? (Note: Accusations which remain open as of the date of this application and which are not confidential by law require a <b>YES</b> response and explanation.) If yes:</p> <ol style="list-style-type: none"> <li>1. List the Jurisdiction(s):            State/Jurisdiction _____ Date _____            State/Jurisdiction _____ Date _____</li> <li>2. Provide a detailed explanation in your own words on a separate sheet of paper.</li> </ol>	<input type="checkbox"/> Yes  <input type="checkbox"/> No

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INITIALS OF APPLICANT

**SECTION 8: CONTINUED**

<p>Has <u>this entity</u> ever been denied registration by the U.S. Drug Enforcement Administration (DEA) or has this entity ever had a DEA Registration modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked this entity's state permit to prescribe or dispense controlled substances? If yes:</p> <ol style="list-style-type: none"><li>1. DEA action <u>OR</u> Other Entity (Name) _____</li><li>2. Submit a copy of the official action by the entity.</li><li>3. Provide a detailed explanation in your own words on a separate sheet of paper.</li></ol>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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**SECTION 9: HOURS OF OPERATION WHICH A PHARMACIST WILL BE AVAILABLE VIA TOLL FREE TELEPHONE - note a.m./ p.m.**

Day	Open	Close
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

**Toll Free Telephone Number:** \_\_\_\_\_

\_\_\_\_\_  
INITIALS OF APPLICANT

**SECTION 10: LIST BELOW EVERY JURISDICTION IN WHICH YOU HOLD OR HAVE EVER HELD A PHARMACY LICENSE.**

**NOTE:** For each of the below, you must submit with this application an official Verification of Licensure from each licensing jurisdiction.

**IMPORTANT:** Applications submitted without all of the Verifications of Licensure from the licensing jurisdiction(s) will not be accepted and your application returned as incomplete.

1. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
2. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
3. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
4. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
5. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
6. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
7. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
8. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
9. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
10. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date

\_\_\_\_\_  
INITIALS OF APPLICANT

**SECTION 10: CONTINUED**

11. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
12. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
13. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
14. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
15. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
16. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
17. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
18. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
19. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
20. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
21. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
22. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
23. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
24. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
25. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date

INITIALS OF APPLICANT

**SECTION 10: CONTINUED**

26. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
27. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
28. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
29. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
30. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
31. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
32. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
33. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
34. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
35. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
36. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
37. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
38. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
39. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date
40. State, Territory, Country	License Number/ Type	Date Issued	Expiration Date

INITIALS OF APPLICANT

## **SECTION 11: NOTICES**

### **Healthcare Integrity and Protection Data Bank (“HIPDB”) Self-Query Reports – this is required for issuance of your license.**

In accordance with 10 MRS §8003(10), all applicants must submit a HIPDB Self-Query Report as part of the initial application for licensure. The instructions to request a self-query report are available at HIPDB’s website: [www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov) The website includes a Fact Sheet on self-querying, as well as FAQs to assist you in requesting a report. Customer Service Contact information: **NPDB-HIPDB Customer Service Center Tel: (800)767-6732 - TDD: (703)802-9395**

### **Public Information**

This application is a public record for purposes of Maine’s Freedom of Access Law, 1 MRS §401, et seq. Public records must be made available to any person upon request. Information that you supply as part of this application (except your Social Security number) is public information. Other licensing records to which this information may later be transferred are also considered public records. Where permitted by law, your name, license number, contact address and other information listed on this application may be posted on the State’s website.

### **10 Day Notification Requirement**

This applicant/licensee must report in writing to the Board the following information no later than 10 days after the change or event, as the case may be:

- a. Change of name or address of the licensee;
- b. A criminal conviction of the licensee or anyone listed on this application as having an ownership interest in the licensee;
- c. A revocation, suspension, or other disciplinary action taken in this or any other jurisdiction against any occupational or professional license held by the applicant/licensee or anyone listed on this application as having an ownership interest in the licensee; or
- d. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the Board.

### **Notice Regarding Social Security Number Disclosure**

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRS section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

INITIALS OF APPLICANT

## **SECTION 12: APPLICANT'S CERTIFICATION AND SIGNATURE**

Read the statement below and sign where indicated as your certification of the information provided on this application.

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false.

The Applicant certifies by his/her signature that the management of the pharmacy will be vested with the licensed pharmacist in all matters directly or indirectly related to the practice of pharmacy or in any matters related to health, welfare, and safety of the public, as required by 32 MRS Section 13752(4).

Printed Name of Applicant	Title
Signature of Applicant	Date
Signature of PIC	Date

Applications that are incomplete, altered, defaced, or compromised will not be accepted and will be returned. This includes, but not limited to, unanswered questions, lack of appropriate signature, information is illegible, missing supporting documents, and/or missing or wrong fee.