



# STATE OF MAINE BOARD OF PHARMACY

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

Pharmacist in Charge

**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** **PHARMACIST IN CHARGE**

**\*\*Fax submissions of applications and supporting documentation will not be accepted.**

This is an abbreviated checklist and does not replace the requirements outlined in the Pharmacy Laws and Rules. You must review them carefully for more detailed and clarifying information. For information on Board Law and Rules see our website at [www.maine.gov/professionallicensing](http://www.maine.gov/professionallicensing).

**Board and Related Laws and Rules.** Laws and rules are available online at our website. This is a short list of the laws and rules you should read and become familiar with:

- Maine Pharmacy law 32 MRS, Chapter 117
- Maine Board of Pharmacy rules 02 392 Chapters 1-32
- Maine Department of Professional and Financial Regulation, Office of Licensing and Registration law 10 M.R.S. §8001-8003 et al.
- Maine Department of Professional and Financial Regulation, Office of Licensing and Registration rules 02 041 Chapters 10, 11, and 13

**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 supporting documents and/or fees are omitted.** Documents that have been modified or altered in any way will not be accepted.

### **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.

## 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.
- **How far back do I go answering the criminal question?** Any conviction, ever.

## 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 MRS §191.

### 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  
INDIVIDUAL LICENSE APPLICATION**

APPLICANT INFORMATION (please print)

NAME OF PHARMACY

PHARMACY LICENSE NUMBER

NAME OF APPLICANT

ANY OTHER NAMES EVER USED:

DATE OF BIRTH      /      /      SOCIAL SECURITY NUMBER      -      -

APPLICANT'S MAILING ADDRESS

CITY      STATE      ZIP      COUNTY

PHONE # (    )      FAX # (    )      E-MAIL

**CRIMINAL BACKGROUND DISCLOSURE**

*NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.*

**1. Have you ever been convicted by any court of any crime? (circle one)      NO      YES**

If yes, enclose a detailed description of what happened (including dates) and a copy of the court judgment.

**2. Has any jurisdiction taken disciplinary action against any professional license you hold or have held, or denied your application for licensure? (circle one)      NO      YES**

If yes, enclose a detailed explanation and copies of all documents.

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.

**SIGNATURE**

**DATE**

**Board of Pharmacy  
Pharmacist in Charge  
Required Fee: \$100.00**

**Office Use Only:**

1457 - \$100.00

*Office Use Only:*

- Reporting of PIC for a New Pharmacy      Fee-\$100.00  
(must accompany the application for the NEW Pharmacy)
- PIC change for currently licensed Pharmacy      Fee-\$100.00

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

**PAYMENT OPTIONS:**

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)      *FIRST*      *MIDDLE INITIAL*      *LAST*

I authorize the Department of Professional and Financial Regulation, Office of Licensing and Registration to charge my

VISA       MASTERCARD      the following amount: \$ \_\_\_\_\_

Card number:      *XXXX-XXXX-XXXX-XXXX*      Expiration Date      *mm / yyyy*

**SIGNATURE**

**DATE**

**SECTION 1: PHARMACY INFORMATION**

Pharmacy Name			
DEA #		Expiration Date	
License Number		Expiration Date	FEIN #
Physical Address	City	State	Zip Code
Contact Address	City	State	Zip Code
Telephone Number		Fax Number	
(     )		(     )	
E-mail Address			

**SECTION 2: THE BOARD OF PHARMACY HOLDS THE PIC RESPONSIBLE FOR ALL PHARMACY RELATED MATTERS.**

Pharmacist in Charge Name			
Pharmacist License Number		Expiration Date	
Contact Address of PIC	City	State	Zip Code
E-mail Address			

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

**SECTION 3: BOARD RULES CHAPTER 7 SECTION 3(3):** Please list all pharmacy technicians\* employed at the pharmacy.

1. Pharmacy Technicians Name	License Number/Expiration Date	Check All That Apply
		<input type="checkbox"/> Registered Technician <input type="checkbox"/> Intern <input type="checkbox"/> Advanced
2. Pharmacy Technicians Name	License Number/Expiration Date	Check All That Apply
		<input type="checkbox"/> Registered Technician <input type="checkbox"/> Intern <input type="checkbox"/> Advanced
3. Pharmacy Technicians Name	License Number/Expiration Date	Check All That Apply
		<input type="checkbox"/> Registered Technician <input type="checkbox"/> Intern <input type="checkbox"/> Advanced
4. Pharmacy Technicians Name	License Number/Expiration Date	Check All That Apply
		<input type="checkbox"/> Registered Technician <input type="checkbox"/> Intern <input type="checkbox"/> Advanced
5. Pharmacy Technicians Name	License Number/Expiration Date	Check All That Apply
		<input type="checkbox"/> Registered Technician <input type="checkbox"/> Intern <input type="checkbox"/> Advanced
6. Pharmacy Technicians Name	License Number/Expiration Date	Check All That Apply
		<input type="checkbox"/> Registered Technician <input type="checkbox"/> Intern <input type="checkbox"/> Advanced
7. Pharmacy Technicians Name	License Number/Expiration Date	Check All That Apply
		<input type="checkbox"/> Registered Technician <input type="checkbox"/> Intern <input type="checkbox"/> Advanced
8. Pharmacy Technicians Name	License Number/Expiration Date	Check All That Apply
		<input type="checkbox"/> Registered Technician <input type="checkbox"/> Intern <input type="checkbox"/> Advanced

\*This applies to pharmacy technicians who are properly registered with the Maine Board of Pharmacy as Pharmacy Technician, Pharmacy Technician Intern, or Pharmacy Technician Advanced. Please make extra copies of the page for additional employees.

INITIALS OF APPLICANT

**SECTION 4 THIS SECTION MUST BE COMPLETED BY THE PHARMACIST IN CHARGE (“PIC”).**

Check appropriate response to the questions below. Any YES response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application.

<p>Have you 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 entities state permit to prescribe or dispense controlled substances? If yes:</p> <p>1. DEA action or Other Entity (Name) _____</p> <p>2. Submit a copy of the official action by the entity.</p> <p>3. Provide a detailed explanation in your own words on a separate sheet of paper.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Have you ever received a sanction from Medicare or from a state Medicaid program?</p> <p>1. Medicare OR Medicaid Program (State) _____</p> <p>2. Submit a copy of the official action by the entity.</p> <p>3. Provide a detailed explanation in your own words on a separate sheet of paper.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION 5 DESIGNATION OF AUTHORIZED PERSONS**

1. First Name	MI	Last Name	Date of Birth
Contact Address		Street or P.O. Box	
City	State	Zip Code	County
Position Title		Purpose	
2. First Name	MI	Last Name	Date of Birth
Contact Address		Street or P.O. Box	
City	State	Zip Code	County
Position Title		Purpose	

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INITIALS OF APPLICANT

**SECTION 5 (CONTINUED): - Designation of Authorized Pharmacy Technicians**

Name	License Number
Name	License Number
Name	License Number

**SECTION 6 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
- c. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the Board.

INITIALS OF APPLICANT

**SECTION 6 (CONTINUED): NOTICES**

**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.

**SECTION 7: WAIVERS REQUESTED (requirements listed in Board Rules Chapter 8 sec. 2):**

Please check all that apply and attached a letter to demonstrate good cause for waiver requested.

- Prescription filling area (Board Rules Chapter 8 section 2 (1))
- Hours of operation (Board Rules Chapter 8 section 2 (2))
- Pharmacist in Charge (PIC) (Board Rules Chapter 8 section 2 (3)) (requires an additional letter for the PIC)

**SECTION 8 APPLICANT’S CERTIFICATION AND SIGNATURE**

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

By signing this application, I attest as Pharmacist in Charge that I will be present in the pharmacy a minimum of 30 hours per week, or 50 percent of the hours per week the pharmacy is open, which ever is less as required by board rules.

By signing this application, I acknowledge that I have read, understand, and agree to uphold the Laws and Rules of the Board and the requirements and duties of a pharmacist in charge (32 MRS §§ 13752 (2)(1)). I have been notified that my name may be reported to various disciplinary data banks if I am sanctioned by the Maine State Board of Pharmacy for violating the Board’s Laws and/ or Rules and that I have answered the above questions. By submitting this application I understand that the Board of Pharmacy will rely upon this information for issuance of my license to be a pharmacist in charge and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension, or revocation of my license if this information is found to be false.

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.

Printed Name of Pharmacist in Charge	
Signature of Pharmacist in Charge	Date

**Pharmacy Self Inspection Checklist – Refer to Chapter 8, Sec. 1(9-14)**

This form must be completed by the Pharmacist in Charge and who must affirm that the pharmacy named on this form is in compliance with Board Rules regarding the requirements for facilities, apparatus and equipment. This checklist must be completed and submitted with the Pharmacist in Charge Application.

Pharmacy Name			
Physical Address	City	State	Zip Code
Pharmacist in Charge Name			
Pharmacist License Number		Expiration Date	

**1. Apparatus and Equipment**

- Adequate lighting
- Sink with hot and cold running water
- Rest room facilities
- Refrigerator of adequate size to meet the need of the pharmacy
- Rx weights (if required by type of Rx balance used)
- Rx balance
- Spatula, non-metal (minimum of 1)
- Spatula, metal (minimum of 2)
- Mortar and pestle (minimum of 2)
- Graduates assorted (minimum of 4)
- Safety cap Rx containers in sufficient quantity to meet the need of the pharmacy
- Appropriate Rx labels
- Professional reference library, including drug interactions (in any format)

List the type of format at this pharmacy

\_\_\_\_\_

- Current Maine pharmacy laws and rules (in any format)

List the type of format at this pharmacy

\_\_\_\_\_

- Appropriate Storage and C-II's Locked
- Minimum amount of prescription inventory (requirement 32 M.R.S. § 13752 (5))
- Class 1000 Room      Expiration date: \_\_\_\_\_
- Class 100 Hood Expiration date: \_\_\_\_\_

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

**Pharmacy Self Inspection Checklist Continued – Refer to Chapter 8, Sec. 1(9-14)**

**2. Security Barrier – Refer to Chapter 13, Sec. 6(4)**

- No barrier exists
- Barrier extends from floor or counter to ceiling
- Barrier is constructed of material of sufficient strength so that the barrier cannot be readily removed
- Barrier is constructed of non-solid material, any openings or interstices must be small enough to prevent the removal, by any means, of items from the prescription filling area
- Confirmation that only a pharmacist or authorized person possesses or has access to the key, combination or activation to the lock

**3. Alarm – Refer to Chapter 13, Sec. 6(5)**

- The electronic security system is separate from any other electronic security system
- The electronic security system is capable of activation/deactivation separately from any other
- Confirmation that only a pharmacist or authorized person possesses or has access to the key combination or activation code to the lock of the electronic security system
- Documentation to verify and confirm installation and operation of the alarm and security system is enclosed with this checklist

**4. Security Cameras**

- Exempted to June 30, 2010
- Security cameras sufficient in number to monitor the critical areas of the department including, at a minimum:
  - The prescription filling area
  - The narcotics safe
  - Check out area

Describe below type of equipment in use.

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**5. Prescription Inventory**

- Schedule II Drugs appropriately stored and locked
- The drug outlet has a sufficient amount of prescription inventory on location to respond appropriately to prescription orders.

INITIALS OF APPLICANT

**Pharmacy Self Inspection Checklist Continued – Refer to Chapter 8, Sec. 1(9-14)**

**6. For Sterile Pharmaceuticals (if applicable)**

Equipment – Reference Chapter 18, Section (2)A-H

- Space complies with Chapter 18 Section 3(1) of Board Rules
- Equipment – Class 1000 room
- Class 100 hood
- Sink with hot and cold running water which is convenient to the compounding area
- Appropriate disposal containers for used needles, syringes, etc., and if applicable, cytotoxic waste
- When cytotoxic drug products are prepared, appropriate environmental control which also includes appropriate biohazard cabinetry
- Refrigerator/freezer with a thermometer
- Temperature controlled delivery container
- Infusion devices, if appropriate

Supplies – Reference Chapter 18, Section 3(3)A-G

- Disposable needles, syringes, and other supplies needed for aseptic admixture
- Disinfectant cleaning solutions
- Hand washing agent with bactericidal action
- Disposable, lint-free towels or wipes
- Appropriate filters and filtration equipment
- Oncology drug spill kit
- Disposable masks, caps, gowns, and sterile disposable gloves

Reference Library – Reference Chapter 18, Section 4

- Sufficient and current reference materials related to sterile products

By signing this self inspection checklist I, the pharmacist in charge, certify I have completed and verified all items checked on this checklist and affirm that the pharmacy is secure, in compliance with applicable State Laws and Rules, and Federal Laws and Rules, governing the practice of pharmacy and is suitable for operation as a pharmacy. By submitting this completed form, I understand that the Maine Board of Pharmacy will rely upon this information for issuance of the pharmacy license and that this information is truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of the pharmacy license and/or my license, if this information is found to be false.

Pharmacist in Charge Name, Print legibly	License number
Signature of Licensed Pharmacist In Charge	Date