



# STATE OF MAINE BOARD OF PHARMACY

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

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**

## **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.
- Plumbing permit, which includes the local plumbing inspector's signature of approval. Even if no plumbing work was done, you must provide a statement from a licensed plumber stating the existing plumbing meets the current plumbing code.
- Electrical permit or written statement from the licensed electrician that the work completed was in compliance with the national electrical code if no permit was required. Even if no electrical work was done, you must provide a statement from a licensed electrician stating the existing electrical meets the current electrical code.
- Satisfactory water test for private water source.
- Scaled drawing and floor plan of the pharmacy which details the usage of each area. If the pharmacy facility is part of a larger retail store, you must include an additional scaled drawing and floor plan of the entire establishment showing the relative position of the pharmacy and location of all entrances, exits, bathrooms, storage areas, security barrier, windows, alarm, and security cameras.
- Facility checklist. This is a checklist of equipment and apparatus required by Board of Pharmacy Rules, Chapter 8, Section 1(5)(a).
- Waiver request if applicable.
- Separate PIC application.
- 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.

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

## Where do I get a NPDB/HIPDB Self Query?

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.***

### **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.

## 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		Expatriation 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 PIC

**Pharmacy Self Inspection Checklist – 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 PIC

## Pharmacy Self Inspection Checklist – 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

### 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 PHARMACY			
FEIN OR SSN			
PHYSICAL LOCATION			
CITY	STATE	ZIP	COUNTY
CONTACT 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  
Pharmacy License  
Required Fee: \$200.00**

**NOTE: A separate Pharmacist in Charge application is required to be filed with this application**

PHARMACY TYPE (check *one* box):

<input type="checkbox"/>	Retail Pharmacy ( <i>PH 1421</i> )	FEE: \$200.00
<input type="checkbox"/>	Rural Health Center Pharmacy ( <i>PH1421</i> )	FEE: \$200.00

*Office Use Only:*  
1421 - \$200.00

*Office Use Only:*

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)	<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:	XXXX-XXXX-XXXX-XXXX	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: PHARMACY DETAIL INFORMATION**

Name of Pharmacy	
Pharmacy Telephone Number	Pharmacy Fax Number
(    )	(    )
E-mail Address	Web Address
DEA #	Expected Opening Date
All Trade Names or Business Name(s) of the Pharmacy	

**\* Important Notice:** Upon issuance, this office will report the Maine pharmacy license number directly to DEA. It is your responsibility to complete and file the appropriate DEA application to secure a DEA #, and to report this number, in writing, to this office immediately upon receipt.

## **SECTION 4: PHARMACIST IN CHARGE INFORMATION.**

Last Name	First Name	Middle Name
Pharmacist License Number	Date of Employment as PIC	

**NOTE:** The Pharmacist in Charge ***must*** complete a PIC application. The completed PIC application must accompany this application.

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INITIALS OF APPLICANT

**SECTION 5: TYPE OF FACILITY**

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

- Retail Chain
- Nuclear Pharmacy
- Opiate Treatment Program/ Center
- Central Fill Pharmacy
- Other: \_\_\_\_\_
- Retail Independant
- Long Term Care Pharmacy
- Automated Dispensing
- Central Fill Processing
- Other: \_\_\_\_\_

**SECTION 6: COMPLETE 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>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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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):					

\_\_\_\_\_  
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):			

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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			
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):			

10. 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 8: THIS SECTION TO BE COMPLETED BY THE 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>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Has <u>this entity</u> ever been notified by the regulatory jurisdiction of any state or province of Canda 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>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<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>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<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>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<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>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

\_\_\_\_\_  
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> <p>1. DEA action <u>OR</u> 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
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**SECTION 9: HOURS OF OPERATION WHICH A PHARMACIST WILL BE ON DUTY** note a.m./p.m.

Day	Open	Close
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

**SECTION 10: IF PHARMACY IS LOCATED WITHIN A RETAIL STORE, LIST STORE HOURS OF OPERATION** note a.m./ p.m.

Day	Open	Close
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

**List the responsible Store Manager/ Director for this Location/ Direct Contact Information**

Last Name	First Name	Middle Name
Title	Telephone Number(s)	
	(    )	(    )
E-mail Address		

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

## **SECTION 11: WAIVER REQUESTS**

- A waiver is not being requested
- A waiver is being requested for the following (check all that apply):
  - Square footage of prescription filling area
  - Minimum hours of operation
  - Presence of Pharmacist in Charge at Pharmacy

A request for waiver must be detailed in a separate letter, signed by the owner of the pharmacy and the PIC and accompany this application.

## **SECTION 12: FLOOR PLAN, ELECTRICAL AND PLUMBING, WATER SUPPLY, AND FACILITY APPARATUS AND EQUIPMENT**

### **A. Floor Plan of Pharmacy**

Scaled drawing and floor plan of the pharmacy which details the usage of each area. Please limit the copy of the floor plan to an 8x11 or 8x14 paper size if possible. If the pharmacy facility is part of a larger retail store, you must include an additional scaled drawing and floor plan of the entire establishment showing the relative position of the pharmacy and location of all entrances, exits, bathrooms, storage areas, security barrier, alarm and security camera. (See Board Rules, Chapter 8, Section 1(10))

#### ***Alert for future alteration of the prescription filling area.***

Pursuant to Board Rules, Chapter 8, Section 7, a retail pharmacy may not alter the physical dimension of the prescription filling area or add or change the doors, windows or other means of access to the prescription filling area prior to receiving approval from the board. The pharmacy shall provide a scaled drawing of the proposed alteration at the time it requests approval.

### **B. Plumbing and Electrical Requirements**

- All plumbing must be in compliance with the Maine Plumbing Code. Documentation certifying compliance by the city or town plumbing inspector is attached to my application.
- All electrical installations must be in compliance with the current edition of the National Electrical Code. Documentation certifying compliance by city or state electrical inspectors is required. A copy is attached to my application.
- Or proof of a Certificate of Occupancy.

### **C. Water Supply**

- Public water supply
- Private water supply. Attach a copy of a recent satisfactory water test for private water sources only.

### **D. Apparatus and Equipment Checklist**

For your information, the Pharmacist in Charge will be required to complete this checklist as part of his or her Pharmacist in Charge application filing. A copy of the checklist content is included with this application for informational purposes only.

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INITIALS OF APPLICANT

## **SECTION 13: 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 14: 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

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.