STATE OF MAINE

BOARD OF PHARMACY

This application information is designed to assist you in completing your application. It does not include all information on laws and rules and it is strongly recommended that you review applicable laws and rules to review the full text related to laws and rules.

Opioid Treatment Program

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

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

Note: The office location address may only be used for overnight deliveries. The office address does not accept postal deliveries. You must use the mailing address for all other regular mail deliveries.

Office Direct Line (207) 624-8620 or Main Receptionist (207) 624-8603
TTY users call Maine relay 711
FAX (207) 624-8637
Web address: www.maine.gov/professionallicensing
Email: pharmacy.lic@maine.gov

FAQ's

Have a question? Please visit our list of Frequently Asked Questions.

Can I come to Gardiner to drop off my application?

No, the Gardiner Annex is closed to the public until further notice due to the Covid-19 pandemic. Please mail your paper application to our mailing address
35 State House Station, Augusta, ME 04333.

APPLICATION INSTRUCTIONS
OPIOID TREATMENT PROGRAM

Board and Related Laws and Rules. Laws and rules are available online at our website. Following is a suggested list of laws and regulations for you to read and become familiar with. This list may not be inclusive, for more detailed information visit our website at www.maine.gov/professionallicensing

- Maine Pharmacy law 32 MRS, Chapter 117
- Maine Board of Pharmacy rules 02 392 Chapters 1-38
- Maine Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation law 10 MRS. §8001-8003 et al.
- Maine Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation rules 02 041 Chapters 10, 11, and 13

The Maine Board of Pharmacy requires that all supporting documents and fees be submitted with the filing of your application. **Your application may be considered incomplete and will be returned to you if supporting documents and/or fees are omitted.** Documents that have been modified or altered (including the use of any white out substance) in any way will not be accepted.

PROCESSING TIME

✓ Applications are processed as quickly as possible in the order received. Please refrain from calling our office regarding the status of your application as numerous calls will delay the timeliness of processing applications. Information regarding the status of applications is available at the Office of Professional and Occupational Regulation's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.

LICENSE RENEWAL

✓ The license is subject to be renewed annually on or before the expiration date of December 31.

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
COMPANY APPLICATION

APPLICANT INFORMATION			
USE BLACK INK ONLY, PRESS FIRMLY			
NAME OF OPIOID TREATMENT PROGRAM			
ALL TRADE OR BUSINESS NAMES OF THE OPIOID TREATMENT PROGRAM			
FEIN OR SSN			
PHYSICAL LOCATION OF THE OPIOID TREATMENT PROGRAM			
CITY	STATE	ZIP	COUNTY
CONTACT ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ( )		FAX # ( )	
EMAIL (for licensing information):			

Maine Board of Pharmacy
Opioid Treatment Program
Required Fee: $200.00 (Non Refundable)

Office Use Only:

OTP1421 - $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 name on card)	
I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my ☐VISA ☐MASTERCARD ☐ AMERICAN EXPRESS ☐DISCOVER the following amount: $_____ ☐ **I understand that fees are non-refundable**	
Card number:	Expiration Date /
SIGNATURE	**DATE**

SECTION 1: TYPE OF APPLICATION

□ Initial Application

□ Change of Ownership □ Change of Location

Date of change _____

Previous License Number: _____
(this license will be terminated upon issuance of new license)

Important, please read: Refer to 32 MRSA §13752, Sec. 3. Please note that a license is not transferrable to another owner or a new location and is subject to a new application and licensure before you begin to operate under new ownership or in a new location.

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

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

Opioid Treatment Program's Telephone Number for the location on this application	**Opioid Treatment Program's Fax Number for the location on this application**
( )	( )
Web Address	
DEA #, when obtained	
**** Important Notice:*** Upon issuance, this office will report the Maine 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. Copy of DEA Registration must be submitted via email to pharmacy.lic@maine.gov. Subject line must say "MELIC-DEA Reporting"	

SECTION 3: HOURS OF DISPENSING note a.m./p.m. NOTE: ALL DAYS MUST BE ENTERED

Day	Open	Close
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

SECTION 4: IF OPIOD TREATMENT PROGRAM IS LOCATED WITHIN ANOTHER BUSINESS, LIST HOURS OF OPERATION note a.m./ p.m.

Day	Open	Close
Sunday		
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		

SECTION 5: APPLICABLE ONLY TO CENTRAL FILL PHARMACY OR PROCESSING (Ref. Chapter 21, Section 3)

☐ *Check here if not applicable*

A central fill drug outlet or central processing center that processes, fills or refills a prescription drug order must have a contract with or have the same owner as the retail drug outlet 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.

If applicable, does this entity have: (check one)

□ A Contract or □ Have the same ownership

SECTION 6: OWNERSHIP. Please check one and complete the appropriate block below.

□ Sole Proprietor *(complete section A)*

□ Partnership *(complete section B)* - If your partnership consists of 2 individuals or more, you must submit an organizational chart.

□ Corporation *(complete section C)* - If you are a corporation, which includes LLC, you must submit a Certificate of Existence from the State of origin. 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. Please be aware the application to file for a certificate of existence is not evidence of having been issued a Certificate of Authority.

□ Non-Profit Corporation (complete section D) - If you are a corporation, which includes LLC, you must submit a Certificate of Existence from the State of origin. 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. Please be aware the application to file for a certificate of existence is not evidence of having been issued a Certificate of Authority.

Section A - Sole Proprietor: (Please type or print legibly) this is information is regarding the **Sole Proprietor:**			
Owner Last Name	**First Name**	**Middle Name**	
Name of Business Entity			
Contact Address	**City**	**State**	**Zip Code**
Telephone Number	**Fax Number**		
( )	**( )**		
E-mail Address	**Website Address**		

SECTION 6: CONTINUED

Section B - Partnership: List the name and address of each partner (please type or print legibly). *Please see Chapter 36, Sec. 3(1)(D)(1)* (If you need more space please use separate sheet)			
PARTNERSHIP INFORMATION:			
Name of partnership			
Contact Address	**City**	**State**	**Zip Code**
E-mail Address			
Telephone Number: ( )			

NAME AND CONTACT INFORMATION OF EACH PARTNER

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

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

Company Name		**FEIN #**	
Contact Address	**City**	**State**	**Zip Code**
E-mail Address	**Telephone number**		
	( )		

Company Name		**FEIN #**	
Contact Address	**City**	**State**	**Zip Code**
E-mail Address	**Telephone number**		
	( )		

SECTION 6 (Continued):

This section applies to Ownership Sections C or D			
Name of Registered Agent			
Contact Address for Registered Agent *If different from Corporation*	**City**	**State**	**Zip Code**
Physical Address for Registered Agent *If different from Corporation*	**City**	**State**	**Zip Code**
Telephone Number	**E-mail Address/ Website Address**		
( )			

Section C - Corporation Ownership: **Please include an organizational chart.**
(Please type or print legibly) *Please see Chapter 36, Sec. 3(1)(D)(1)*

SECTION 6-C (Con't): CORPORATION OWNERSHIP Please see *Chapter 36, Sec. 3(1)(D)(1)*

Is this corporation's stock traded on a major stock exchange and not over-the-counter

YES ☐ NO ☐ If no, complete the section below—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. Use a separate sheet of paper if needed.

Shareholder name or individual shareholder			
Contact Address	**City**	**State**	**Zip Code**
Telephone Number	**E-mail Address**		
( )			

SECTION 6C (Continued):

Shareholder name or individual shareholder			
Contact Address	**City**	**State**	**Zip Code**
Telephone Number	**E-mail Address**		
( )			

Shareholder name or individual shareholder			
Contact Address	**City**	**State**	**Zip Code**
Telephone Number	**E-mail Address**		
( )			

Shareholder name or individual shareholder			
Contact Address	**City**	**State**	**Zip Code**
Telephone Number	**E-mail Address**		
( )			

SECTION 6-C (Con't): CORPORATE OFFICER(S) AND DIRECTOR

1. Last Name	First Name	Middle Name	
Title			
Address	**City**	**State**	**Zip Code**

2. Last Name	First Name	Middle Name	
Title			
Address	**City**	**State**	**Zip Code**

3. Last Name	First Name	Middle Name	
Title			
Address	**City**	**State**	**Zip Code**

4. Last Name	First Name	Middle Name	
Title			
Address	**City**	**State**	**Zip Code**

SECTION 6: CONTINUED - NON-PROFIT COROPORATION INFORMATION:

Section D - Non-Profit Corporation: List the name and address of each corporate officer and director (please type or print legibly). *Please see Chapter 36, Sec. 3(1)(D)(3)* (If you need more space please use separate sheet)			
Name of corporation			
Contact Address	**City**	**State**	**Zip Code**
E-mail Address			
Telephone Number : ( )			
Name of Parent Company (if any)			

NAME AND CONTACT INFORMATION OF EACH CORPORATE OFFICER AND DIRECTOR

1. Last Name	**First Name**	**Middle Name**	
Title			
Address	**City**	**State**	**Zip Code**

2. Last Name	**First Name**	**Middle Name**	
Title			
Address	**City**	**State**	**Zip Code**

NAME AND CONTACT INFORMATION OF EACH VOTING MEMBER (*If you need more space, please use separate sheet)*

1. Last Name	First Name	Middle Name	
Address	**City**	**State**	**Zip Code**

2. Last Name	First Name	Middle Name	
Address	**City**	**State**	**Zip Code**

3. Last Name	First Name	Middle Name	
Address	**City**	**State**	**Zip Code**

4. Last Name	First Name	Middle Name	
Address	**City**	**State**	**Zip Code**

5. Last Name	First Name	Middle Name	
Address	**City**	**State**	**Zip Code**

6. Last Name	First Name	Middle Name	
Address	**City**	**State**	**Zip Code**

SECTION 6: CONTINUED - LIMITED LIABILITY COROPORATION INFORMATION:

Section E - Limited Liability Corporation: List the name and address of each member and manager (please type or print legibly). *Please see Chapter 36, Sec. 3(1)(D)(4)* (If you need more space please use separate sheet)			
Name of corporation			
Contact Address	**City**	**State**	**Zip Code**
E-mail Address			
Telephone Number: ( )			

NAME AND CONTACT INFORMATION OF EACH MEMBER AND MANAGER *(If you need more space, please use separate sheet)*

1. Last Name	**First Name**	**Middle Name**	
Address	**City**	**State**	**Zip Code**

2. Last Name	**First Name**	**Middle Name**	
Address	**City**	**State**	**Zip Code**

3. Last Name	**First Name**	**Middle Name**	
Address	**City**	**State**	**Zip Code**

4. Last Name	**First Name**	**Middle Name**	
Address	**City**	**State**	**Zip Code**

SECTION 6: CONTINUED - LIMITED LIABILITY COROPORATION INFORMATION:

Section E - Limited Liability Corporation: List the name of member or manager that will be representing applicant in matters before the Board (please type or print legibly). *Please see Chapter 36, Sec. 3(1)(D)(4)* (If you need more space please use separate sheet)			
Name Member or Manager			
Contact Address	**City**	**State**	**Zip Code**
Telephone Number			
( )			
E-mail Address			

SECTION 7: THIS SECTION TO BE COMPLETED BY THE OPIATE TREATMENT PROGRAM OWNERS OR OFFICERS (Reference Chapter 36 Section 3 (2))

Have you or has any corporate officers, owners, or the designated officer of this entity been convicted of any criminal offense? If yes: 1. Provide a detailed explanation in the offender's own words on a separate sheet of paper. 2. Attach a copy of the Court Judgment and Decision. 3. If a motor vehicle criminal offense, attach a copy of a recent motor vehicle report.	☐ Yes ☐ No
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: 1. List the jurisdiction(s) that denied your license or issued discipline and date of action: State/Jurisdiction_____ Date _____ State/Jurisdiction_____ Date _____ 2. Submit a copy of the consent agreement or decision and order for each of the above. 3. Provide a detailed explanation in your own words on a separate sheet of paper.	☐ Yes ☐ No
Has this entity 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: 1. DEA action OR Other Entity (Name) _____ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper.	☐ Yes ☐ No
Has this entity ever been issued a citation, warning letter or untitled letter by FDA or similar action take by any governmental board?	☐ Yes ☐ No

SECTION 8: Opioid Treatment Program Self Inspection Checklist – Refer to Chapter 36, Sec. 3(1)(F)

Complete this checklist by applying ☒ as appropriate— if not completed fully application will be considered incomplete

Apparatus and Equipment

☐ Automated Data Processing System

☐ Appropriate Containers

☐ Prescription labels imprinted or computer-generated with the name, address, and telephone number of the opioid treatment program that do not contain any symbol or background logo that interfaces with the reding and interpretation of any information written by the pharmacist on the label

☐ Auxiliary Labels

☐ Sufficient equipment to maintain the scope of practice

☐ Patient Counseling (Chapter 36 section 4 (4))

☐ Sufficient Waste Receptacles

☐ Sufficient Equipment to Maintain Scope of Practice

☐ Appropriate Prescription Labels

☐ Rest Room Facilities (Employees/Patients)

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

Security Cameras Refer to Chapter 13, Sec. (6)

☐ 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. (use separate sheet if necessary)

_____

_____

SECTION 9: FLOOR PLAN, ELECTRICAL AND PLUMBING, WATER SUPPLY, AND FACILITY APPARATUS AND EQUIPMENT

You must select the appropriate boxes below or this application will be considered incomplete.

A. **Floor Plan of Opioid Treatment Program you must submit a scaled drawing with this application**

Reference Board Rules, Chapter 36, Section 3(1)(E))

Alert for future alteration of the prescription filling area. Reference Board Rules, Chapter 36 Section 3(9)

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.

SECTION 10: NOTICES

Please Note:
Pursuant to 10 MRS §8003-G - any change in name, address, email address, criminal convictions, disciplinary actions, or any material change set forth in your original application for licensure must be reported to the Office within 10 days.

You can access this Law for your review at:
http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html

Email Address: Your email address will be used for purposes of license renewal online and any notifications regarding your professional license status. Your email address on file with this office must be current in order to retrieve your access code at any time if it is lost after it is issued. It is important that your correct and current email address be on file with this office at all times.

SECTIONS 10 thru 16 MUST BE COMPLETED BY THE PHARMACIST IN CHARGE

(32 MRSA §13702-A (23)) "Pharmacist in charge means the pharmacist who is responsible for the licensing of the Opioid Treatment Program''

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35 State House Station, Augusta ME 04333 Website: www.maine.gov/professionallicensing

SECTIONS 10 thru 16 MUST BE COMPLETED BY THE PHARMACIST IN CHARGE (PIC)

SECTION 11: PHARMACIST IN CHARGE INFORMATION *(32 MRSA §13702-A (23)) "Pharmacist in charge means the pharmacist who is responsible for the licensing of the pharmacy,"*
THE MAINE 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			

SECTION 12: BOARD RULES CHAPTER 7 SECTION 3(3):
Please list all pharmacy technicians* employed at the treatment center. (Use separate sheet if necessary)
*This applies to pharmacy technicians who are properly registered with the Maine Board of Pharmacy as Pharmacy Technician Please make extra copies of the page for additional employees.

1. Pharmacy Technicians Name	**License Number**	**Expiration Date**
2. Pharmacy Technicians Name	**License Number**	**Expiration Date**
3. Pharmacy Technicians Name	**License Number**	**Expiration Date**
4. Pharmacy Technicians Name	**License Number**	**Expiration Date**
5. Pharmacy Technicians Name	**License Number**	**Expiration Date**
6. Pharmacy Technicians Name	**License Number**	**Expiration Date**
7. Pharmacy Technicians Name	**License Number**	**Expiration Date**

SECTION 13 DESIGNATION OF AUTHORIZED PERSONS (See Ref. Board Rule, Ch. 1, Sec. 1)

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**	

DESIGNATION OF AUTHORIZED PHARMACY TECHNICIANS
(See Ref. Board Rule, Ch. 1, Sec. 2)

Name	License Number
Name	**License Number**
Name	**License Number**

SECTION 14: THIS SECTION APPLIES ONLY TO REQUEST FOR WAIVER(S) (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.

□ Minimum 40 hours per week of operation

□ Practice by the pharmacist in charge at the drug outlet for which he or she has registered for a minimum of 30 hours per week or 50% of the hours that the retail drug outlet is open, whichever is less.

SECTION 15: Con't Opioid Treatment Program Self Inspection Checklist

Prescription Inventory

□ Narcotics (Rules, Chapter 13 (6))

□ Locked Safe or □ Dispersed though inventory

□ The Opioid Treatment Program has a sufficient amount of prescription inventory on location to respond appropriately to prescription orders.

SECTION 16: PHARMACIST IN CHARGE INFORMATION

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.

Have you ever been denied registration by the U.S. Drug Enforcement Administration (DEA) or have you ever had a DEA Registration modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked your state permit to prescribe or dispense controlled substances? If yes: 1. □ DEA action □ Other State of Province (Name) _____ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper.	□ Yes □ No

SECTION 16: Con't PHARMACIST IN CHARGE INFORMATION

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

Have you, the pharmacist in charge, **ever** been denied registration by the U.S. Drug Enforcement Administration (DEA) or have you ever had a DEA Registration modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked your state permit to prescribe or dispense controlled substances? If yes: 1. □ DEA action □ Other State of Province (Name) _____ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper.	□ Yes □ No
Have you, the Pharmacist in Charge, **ever** received a sanction from Medicare or from a state Medicaid program? 1. Medicare OR Medicaid Program (State) _____ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper. Clarification on programs: • Medicare – Health program administered by the United States government for people that are (1) ages 65 or older, (2) under the age of 65 with certain disabilities, and/or (3) all ages with end-stage renal disease. • Medicaid – Health program administered by the United States government for people with limited incomes. • MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid.	□ Yes □ No
Has any jurisdiction **ever** taken disciplinary action against any professional license you, the Pharmacist in Charge, hold or have held, or denied your application for licensure? If yes, enclose a detailed explanation and copies of consent agreement or board order.	□ Yes □ No
Has this entity **ever** been issued a citation, warning letter or untitled letter by FDA or similar action take by any governmental board?	□ Yes □ No

As the Pharmacist in Charge I certify by my signature that I have read and understand the Maine Board of Pharmacy laws and rules and related laws and rules as it applies to Pharmacy. I also certify that the management of the pharmacy will be vested with the pharmacist in charge 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 laws and rules.

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

Pharmacist in Charge Name (print legibly)	License number
Signature of Licensed Pharmacist in Charge	Date

OPIOID TREATMENT PROGRAM—Checklist affirmation

Please check mark each box to affirm that you have enclosed the information and documents required for this application. This affirmation checklist does not replace the requirements outlined in the Board of Pharmacy Laws and Rules. Please review them carefully for more detailed and clarifying information. This checklist is designed as a tool to confirm that your application is complete and ready to forward to our office.

DID YOU ENCLOSE THE FOLLOWING:

Please review the list below to ensure you are filing a complete application. If the application is not yet complete, please wait until you have all of the required documentation to submit with this application.

◊ Each section of the application is completed.

◊ Signature present where noted.

◊ Payment in the amount of $200 is enclosed.

◊ Floor plan

◊ Company Organizational Chart

◊ A signed copy of the consent agreement or order issued by the Board/Jurisdiction if discipline has been indicated.

◊ A copy of the Court Judgment and Decision if convicted of a crime, including a signed written statement, in your words, regarding the details of the crime.

◊ Certificate of Existence from your home state

◊ Maine Certificate of Authority

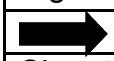
◊ Federal DHHS Certification must be submitted with the application

◊ Maine DHHS License must be submitted with the application

SECTION 17: 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 and in accompanying documents 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 affirm that I have provided an accurate list of all states in which I hold or have ever held a pharmaceutical license and any disciplinary action taken in another a state of jurisdiction. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false. I also acknowledge that an incomplete, altered, defaced, including use of white out, or compromised application will not be accepted and will be returned and fees forfeited. This includes, but is not limited to, unanswered questions, lack of appropriate signature, illegible, missing supporting documents, and/or missing or wrong fee.

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