MAINE
BOARD OF PHARMACY

Application information to assist
in completing your application. This information is not designed to include all information on laws and rules and it is strongly recommended that you review applicable laws and rules.

Pharmacy
Change of Pharmacist in Charge
For A Licensed Pharmacy Located in the
State of Maine

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

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

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

APPLICANT INFORMATION (please print)			
NAME OF PHARMACY			
FEIN OR SSN			
PHYSICAL LOCATION OF THE PHARMACY			
CITY	STATE	ZIP	COUNTY
CONTACT ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ( )		FAX # ( )	
PERSON RESPONSIBLE FOR COMPLETING AND SUBMITTING APPLICATION			

Maine Board of Pharmacy
Change of Pharmacist in Charge
for a Licensed Pharmacy Located in the State of Maine
$50.00 (non-refundable)

PAYMENT OPTIONS:
Make checks payable to "Maine State Treasurer" - If you wish to pay by credit card, fill out the following:
NAME OF CARDHOLDER (please print) *FIRST* *MIDDLE INITIAL* *LAST*
MAILING ADDRESS OF CARDHOLDER (please print)
I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN EXPRESS The following amount: $_____ ☐ **I understand that fees are non-refundable**
Card number: Expiration Date *mm / yyyy*
SIGNATURE **DATE**

Maine Pharmacy License #

PH_____

Expiration Date_____

Office Use Only

PIC 1457

Office Use Only
Check #_____
Amount:_____
Cash#_____
Lic #_____

SECTION 1: COMPANY INFORMATION

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

SECTION 2: 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 3: EFFECTIVE DATE OF CHANGE

Effective date you, the pharmacist in charge, will take over as PIC
Name of Pharmacist In Charge you are replacing:

SECTION 4: PHARMACY TECHNICIAN REPORT Please list all pharmacy technicians* employed at the pharmacy. (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 Technician's Name	License Number	Expiration Date
2. Pharmacy Technician's Name	License Number	Expiration Date
3. Pharmacy Technician's Name	License Number	Expiration Date
4. Pharmacy Technician's Name	License Number	Expiration Date
5. Pharmacy Technician's Name	License Number	Expiration Date
6. Pharmacy Technician's Name	License Number	Expiration Date

SECTION 5: 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	

SECTION 6: THIS SECTION APPLIES ONLY TO WAIVER REQUEST(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 pharmacy is open, whichever is less.

SECTION 7: 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:
https://www.maine.gov/pfr/professionallicensing/professions/board-pharmacy/home/laws-rules

SECTION 8: 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, 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

SECTION 9: LAWS AND RULES REFERENCE

Information contained in this application is not a substitute for carefully reviewing applicable laws and rules. You may obtain a copy of the laws and board rules online at:
https://www.maine.gov/pfr/professionallicensing/professions/board-pharmacy/home/laws-rules

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.

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

◊ SECTION 10: SIGNATURE AND AFFIRMATION

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

As the Pharmacist in Charge I acknowledge and certify by my signature that I have read, understand, and will abide by 32 MRS Chapter 117 of the Maine Pharmacy Act and the related Laws and Rules. I also acknowledge my duties and responsibilities to the management and operation of the pharmacy named in this application in all matters directly or indirectly related to the practice of pharmacy including, but not limited to, any matters related to the health, welfare, and the safety of the public.

By submitting this completed form, I understand that the Maine Board of Pharmacy will rely upon this information as being truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of the pharmacy license and/or my pharmacist license, if this information is found to be false.

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