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.

Mail Order Pharmacy
(Not located in the State of Maine)
Change of Pharmacist in Charge

Do not return the 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

INFORMATIONAL

- Your application has greater chance of being processed expeditiously if it is complete and all supporting documents are attached. Action on this application is posted to the web in real time. Please visit our website if you wish to monitor progress. If the status appears as Pending, this means that your application was received by this office and it is pending or under review. Once reviewed and if everything about your application is complete and complies with requirements, the license will be issued and the status will show as ACTIVE. If incomplete and a letter is being sent to you, the letter will be available for you to see online.

- Please refrain from calling our office to "check" on your application as these calls only serve to slow our ability to review and process applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.

- If there is an urgent need to contact us, please be advised that we will only discuss your application with the contact person named in the application to avoid miscommunications. This is done not only for your protection, but to also avoid any complications with too many hands involved, which generally leads to miscommunication or misunderstandings. Our goal is to streamline your process, not complicate it.

- Incomplete applications or documents that have been modified or altered in any way, including use of a white out substance will not be accepted and will be returned.

LAW AND BOARD RULE REFERENCE

Information contained in this application is not a substitute for carefully reviewing applicable laws and rules. You may view all laws and rules on our website at the following link: https://www.maine.gov/pfr/professionallicensing/professions/board-pharmacy/home/laws-rules

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

APPLICANT INFORMATION (please print)			
NAME OF MAIL ORDER PHARMACY			
FEIN OR SSN			
PHYSICAL LOCATION OF THE MAIL ORDER PHARMACY			
CITY	STATE	ZIP	COUNTY
CONTACT ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ( )		FAX # ( )	
PERSON RESPONSIBLE FOR COMPLETING AND SUBMITTING APPLICATION (must be an owner or officer of the entity)			

Maine Board of Pharmacy
Change of Pharmacist in Charge
for a Mail Order Pharmacy
$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 Mail Order Pharmacy License #

MO_____

Expiration Date_____

Office Use Only

PIC1457

Office Use Only
Check #_____
Amount_____
Cash #_____
Lic #_____

SECTION 1: COMPANY INFORMATION

Name of Mail Order Pharmacy	
Mail Order Pharmacy Telephone Number	Mail Order Pharmacy Fax Number
( )	( )
Toll-Free Telephone Number	E-mail Address
( )	
Web Address	DEA # *(Required pursuant to Rules, Chapter 11, Section 1 (1)(E), if not applicable, you must provide a written statement)*
All Trade Names or Business Names of the Mail Order 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,'' and the contact person for this office for licensing the mail order pharmacy.)*

Last Name	First Name	Middle
Contact Address		
City	State	Zip Code
Telephone Number	E-mail Address	
License Number:	State Issued	License Expiration Date:

EFFECTIVE DATE OF CHANGE

Effective date you, the pharmacist in charge, will take over as PIC

SECTION 2 Con't—PHARMACIST IN CHARGE INFORMATION

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.

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
Have you **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 hold or have held, or denied your application for licensure? If yes, enclose a detailed explanation and copies of all documents.	□ Yes □ No

SECTION 3: 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

Notice to Consumers (Board Rule Chapter 11, Section 5)

A mail order prescription pharmacy and mail order contact lens supplier shall include with each prescription filled prominent notice that complaints against the mail order prescription pharmacy may be filed with the Complaint Coordinator, Office of Professional and Occupational Regulation, 35 State House Station, Augusta, ME 04333.

SECTION 4: CERTIFICATION AND SIGNATURES

Read the statement below and sign where indicated as your certification of the information provided on this application. Applications that are incomplete, altered (including use of any white out), 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 required supporting documents, and/or missing or wrong fee.

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 Mail Order Pharmacy Owner or Officer	Title
Signature of Mail Order Pharmacy Owner or Officer	Date

Also, as the Pharmacist in Charge 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 a Mail Order 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.

Printed Name of PIC	Title
Signature of PIC	Date