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
(Pharmacies NOT located in Maine)

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.

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.

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

INFORMATIONAL

- ✓ Receipt of your application does not constitute entitlement to begin to ship into Maine. While applications are logged in as 'pending' this does not mean a license has been issued. You must hold an active license in order to begin shipping into Maine. Processing time depends greatly on the completeness of your application.

- ✓ 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.

- ✓ Once your license is issued it is immediately visible online with an "active" status. Licenses are printed off site and require at least 14 business days for delivery.

- ✓ 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 obtain a copy of the laws and board rules online at www.maine.gov/professionallicensing—Click on "list of licensed professionals", click on "Pharmacy" under "Board of Pharmacy Home" click on "Laws & Rules"

Notwithstanding, please pay particular attention to the following:

- 32 MRSA Chapter 117, Subchapter 5
- Board Rules, Chapter 11

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
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ( )		FAX # ( )	
PERSON RESPONSIBLE FOR COMPLETING AND SUBMITTING APPLICATION (must be an owner or officer of the entity)			
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 Professional and Occupational Regulation 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**	

Maine Board of Pharmacy
Mail Order Pharmacy
(Pharmacies NOT located in Maine)
Required Fee: $200.00 (Non Refundable)

Office Use Only:	*Office Use Only:*
MO1421 - $200.00	Check #_____ Amount:_____ Cash #_____ Lic. #_____ Issue Date_____ Exp. Date_____

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**	

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: 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)*
Trade Names or Business Name of the Mail Order Pharmacy	

SECTION 3: TYPE OF FACILITY

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

☐ Retail Chain ☐ Retail Independent

☐ Nuclear Pharmacy ☐ Long Term Care Pharmacy

☐ Opiate Treatment Program/Center ☐ Automated Dispensing

☐ Central Fill Pharmacy ☐ Central Fill Processing

☐ Other: _____ ☐ Other: _____

SECTION 4: HOURS OF OPERATION WHICH A PHARMACIST WILL BE AVAILABLE VIA TOLL FREE TELEPHONE - note a.m./ p.m.

Toll-Free Telephone Public Access #_____

Day	Open	Close
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

SECTION 5: 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 corporations or more, you must submit a list of officers and 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.

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

SECTION 5: CONTINUED

Section B - Partnership: List the name and address of each partner (please type or print legibly). *Please see Chapter 11, Sec. 1(1)(D)(1))* (If you need more space please use separate sheet)			
PARTNERSHIP INFORMATION:			
Name of partnership			
Contact Address	City	State	Zip Code
Telephone Number		FEIN Number	
( )			
E-mail Address			

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 Number	
Contact Address	City	State	Zip Code
E-mail Address		Telephone number	
		( )	

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

SECTION 5 (Continued):

Section C - Corporation Ownership: Please include an organizational chart. (Please type or print legibly) *Please see Chapter 11, Sec. 1(1)(D)(2))*			
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	
Name and 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 5-C (Con't): CORPORATION OWNERSHIP Please see *Chapter 11, Sec. 1(1)(D)(2))*

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.

1. Last Name	First Name	Middle Name	
Address	City	State	Zip Code
E-mail Address		Telephone Number	
		( )	

2. Last Name	First Name	Middle Name	
Address	City	State	Zip Code
E-mail Address		Telephone Number	
		( )	

3. Last Name	First Name	Middle Name	
Address	City	State	Zip Code
E-mail Address		Telephone Number	
		( )	

4. Last Name	First Name	Middle Name	
Address	City	State	Zip Code
E-mail Address		Telephone Number	
		( )	

SECTION 5-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: THIS SECTION TO BE COMPLETED BY A MAIL ORDER PHARMACY OWNER OR OFFICER

Have you ever or has any corporate officer, owner, or the designated officer of this entity been convicted of any criminal offense? If yes: 1. Provide a detailed explanation of the offense 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 this entity's or predecessor entity's 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
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 7: LIST OF JURISDICTIONS IN WHICH YOU HOLD OR HAVE EVER HELD A PHARMACEUTICAL LICENSE.

On a separate sheet, list each state or jurisdiction the applicant has at any time held a pharmaceutical license, including controlled substance licenses.

The information must include the following:

State, Territory, Country	License Number & Lic Type	Date Issued	Expiration Date	Was discipline ever imposed? Yes / No

Optional: For your convenience a form to report this information is available online from our applications and forms section entitled "Reporting Jurisdictions of Licensure."

If discipline was imposed, you must submit a copy of the consent agreement or order issued by the Board.

SECTION 8: 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 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.

<u>SECTION 9:</u> 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 PIC is the contact person for this office for licensing the mail order pharmacy and duties as described in the Rules.)*

Last Name	First Name	Middle

Contact Address

City	State	Zip Code

Telephone Number	E-mail Address

License Number:	State Issued	License Expiration Date:

SECTION 9: 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. **CRIMINAL BACKGROUND DISCLOSURE** *NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.*

Have you, the Pharmacist in Charge, 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: 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
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
Have you, the Pharmacist in Charge, ever been convicted by any court of any crime? If yes, enclose a detailed description of what happened (including dates) and a copy of the court judgment.	□ 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 all documents.	□ Yes □ No

SECTION 9: Con't PHARMACIST IN CHARGE INFORMATION

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 PIC	
Signature of PIC	Date
	

MAIL ORDER PHARMACY—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 Maine 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.

CHECKLIST—please checkmark as an indicator that you have completed the following.

- ☐ Each section of the application has been completed.
- ☐ Each page of the application, where noted, has been initialed.
- ☐ Signature present where noted.
- ☐ Check made payable to: Treasurer State of Maine in the amount of $200.00 is enclosed, or Credit card authorization completed.
- ☐ Most recent inspection report from the state in which this facility is located. If the state board or jurisdiction does not conduct inspections of the facility, check here ☐ **and** submit with this application a confirmation statement from the state board or jurisdiction.
- ☐ Company's organizational chart.
- ☐ You must disclose all states in which you hold or have held a license and sign an affirmation statement to this effect.
- ☐ A copy of the consent agreement or order issued by the Board or jurisdiction is enclosed if licensure discipline has been indicated.
- ☐ A copy of the Court Judgment and Decision is enclosed if convicted of a crime, including a written statement, in your words, regarding the details of the crime.
- ☐ If you are a corporation, or a 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 (see sample attached). 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 Existence.
- ☐ DEA number. If not applicable, you must submit a written statement.

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. 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 Applicant	Title
Signature of Applicant	Date
Signature of PIC	Date