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
(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.

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.

Published under appropriation 01402A4350012 **Revised 3/2022**
35 State House Station, Augusta ME 04333 Website: www.maine.gov/professionallicensing

INFORMATIONAL

- ✓ Receipt of your application does not constitute entitlement to begin to do business in 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 do business in 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 professions", 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 8

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
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
Pharmacy
Required Fee: $200.00 (Non-Refundable)

Office Use Only:	*Office Use Only:*
PH1421 - $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: 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: COMPANY INFORMATION

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

INITIALS OF APPLICANT

SECTION 4: TYPE OF FACILITY

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

Chain Pharmacy

Independent Pharmacy

Long Term Care Pharmacy

Central Fill Processing

Automated Dispensing

Central Fill Pharmacy

Hospital Pharmacy (other than in patient services)

Veterinary or Animal Specialty Pharmacy

Other: _____

SECTION 5: 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 6: IF PHARMACY IS LOCATED WITHIN A RETAIL STORE, LIST RETAIL STORES HOURS OF OPERATION

note a.m./ p.m. ☐ **(check here if this section is not applicable)**

Day	Open	Close
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

_____ **INITIALS OF APPLICANT**

SECTION 6 Con't: List the responsible Store Manager/ Director for this Location/ Direct Contact Information (check here if this section is not applicable)

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

SECTION 7: APPLICABLE ONLY TO CENTRAL FILL PHARMACY OR PROCESSING

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 8: 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		

INITIALS OF APPLICANT

SECTION 9: CONTINUED

Section B - Partnership: List the name and address of each partner (please type or print legibly). *Please see Chapter 8, Sec. 1(4)(A)* (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 #	
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	
		( )	

INITIALS OF APPLICANT

SECTION 10 (Continued):

Section C - Corporation Ownership: Please include an organizational chart. (Please type or print legibly) *Please see Chapter 8, Sec. 1(4)(B)*			
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	
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		
( )			

INITIALS OF APPLICANT

SECTION 10-C (Con't): CORPORATION OWNERSHIP Please see *Chapter 8, Sec. 1(4)(B)*

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	
		( )	

INITIALS OF APPLICANT

SECTION 10-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

_____ INITIALS OF APPLICANT

SECTION 4 (Continued):

Section D - Limited Liability Company: (Please type or print legibly) *Please see Chapter 12, Sec. 2(5)(C)*			
Name of Limited Liability Company			
Assumed Name (d/b/a)			
Name of Parent Company, if any			
FEIN #			
Contact Address of Limited Liability Company	City	State	Zip Code
Physical Address of Limited Liability Company	City	State	Zip Code

Telephone Number	Fax Number
( )	
E-mail Address	Website Address

Name of Member or Manager Representing Applicant Before the Board			
Mailing Address of Representative	City	State	Zip Code
Telephone Number	E-mail Address		
( )			

Corporate Registration Certificate Number	Issued Under What Jurisdiction	Date	
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		
( )			

INITIALS OF APPLICANT

SECTION 11: THIS SECTION TO BE COMPLETED BY THE PHARMACY OWNER OR OFFICER

Have you or has any corporate officers, owners, or the designated officer of this entity **ever** 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

_____ INITIALS OF APPLICANT

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

A. Floor Plan of Pharmacy

Submit scaled drawings and floor plans of the pharmacy which details the usage of each area. Please limit the copy of the floor plan to an 8"x11" or 8"x14" 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.

SECTION 13: 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

_____ INITIALS OF APPLICANT

SECTIONS 14 thru 19 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 pharmacy''

INITIALS OF APPLICANT

Published under appropriation 01402A4350012 **Revised 3/2022**
35 State House Station, Augusta ME 04333 Website: www.maine.gov/professionallicensing

SECTIONS 14 thru 19 MUST BE COMPLETED BY THE PHARMACIST IN CHARGE (PIC)

SECTION 14: 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 RE-LATED MATTERS.
SECTION 15: BOARD RULES CHAPTER 7 SECTION 3(3): Please list all pharmacy technicians*

Pharmacist in Charge Name			
Pharmacist License Number	Expiration Date		
Contact Address of PIC	City	State	Zip Code
E-mail Address			

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 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

_____ INITIALS OF APPLICANT

SECTION 16 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 17: 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.

INITIALS OF PIC

SECTION 18: Pharmacy Self Inspection Checklist – Refer to Chapter 8, Sec. 1

THIS SECTION MUST BE COMPLTED BY THE PHARMACIST IN CHARGE ("PIC") 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.

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

□ Paper □Internet □ Other_____

_____

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

_____ INITIALS OF PIC

SECTION 18: Con't Pharmacy Self Inspection Checklist

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

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

□ Security cameras sufficient in number to monitor the critical areas of the department including, at a minimum:

- Prescription filling area
- Controlled drug storage areas (effective July 1, 2014) □ check here if you are currently compliant
- Narcotics safe
- Check out area
- Will call area
- Shipping area
- Gowning room
- Clean room
- Self-service customers kiosks

Dispensing Machine

Describe below type of equipment in use. (use separate sheet if necessary)

_____

_____

5. **Prescription Inventory** □ Narcotics (Rules, Chapter 13 (6))
□ Locked Safe or □ Dispersed though inventory

□ The drug outlet has a sufficient amount of prescription inventory on location to respond appropriately to prescription orders.

INITIALS OF PIC

SECTION 19: 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. **CRIMINAL BACKGROUND DISCLOSURE** *NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.*

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, 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
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

_____ INITIALS OF PIC

SECTION 19: Con't PHARMACIST IN CHARGE INFORMATION

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

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 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
	

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.
◊ Each page of the application, where noted, has been initialed.
◊ Signature present where noted.
◊ Payment in the amount of $200 is enclosed.
◊ Most recent inspection report from the state in which the facility is located.
◊ Company Organizational Chart
◊ List of Jurisdictions you are/have been licensed in *(in the format given in section 7).*
◊ 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

SECTION 20: 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