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.

Rural Health Center

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.

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 and 7
- Board Rules, Chapter 9

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

APPLICANT INFORMATION (please print)			
NAME OF RURAL HEALTH CENTER			
FEIN OR SSN			
PHYSICAL LOCATION OF THE RURAL HEALTH CENTER			
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
Rural Health Center
Required Fee: $200.00 (Non Refundable)

Office Use Only:

PH1421 - $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 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 □ Change of Consultant Pharmacist

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, new location or change in consultant pharmacist and is subject to a new application and licensure before you begin to operate under new ownership, at a new location or under a new consultant pharmacist .

SECTION 2: CENTER TO BE LICENSED *(Ref. 32 MRS, Section 13762).*

This Rural Health Center is which of the following:

- □ It serves a rural area without a pharmacy;
- □ It is located in a community where available pharmacy services can not meet the documented need; or
- □ It requires a license in order to receive pharmaceutical discounts authorized by the federal Veterans' Health Care Act of 1992, Title VI.

SECTION 3: CONTACT INFORMATION *(person responsible for completing and submission of application must be an owner or officer of the entity).*

<table>
<tr><td>Last Name</td><td colspan="2">First Name</td><td colspan="2">Middle Name</td></tr>
<tr><td></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>Contact Address</td><td>City</td><td colspan="2">State</td><td>Zip Code</td></tr>
<tr><td></td><td></td><td colspan="2"></td><td></td></tr>
<tr><td>Telephone Number</td><td colspan="4">E-mail Address</td></tr>
<tr><td>( )</td><td colspan="4"></td></tr>
</table>

SECTION 4: COMPANY INFORMATION

<table>
<tr><td colspan="2">Name of Rural Health Center</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>Rural Health Center Telephone Number</td><td>Rural Health Center Fax Number</td></tr>
<tr><td>( )</td><td>( )</td></tr>
<tr><td colspan="2">E-mail Address</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">Web Address</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td colspan="2">All Trade Names or Business Names of the Rural Health Center</td></tr>
<tr><td colspan="2"></td></tr>
</table>

________ **INITIALS OF APPLICANT**

SECTION 5: OWNERSHIP

Private Nonprofit Corporation: Please include an organizational chart.
(Please type or print legibly) *Please see Board Rules, Chapter 9, Sec. 1(1)*

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 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 6: CORPORATE OFFICER(S) AND DIRECTOR(S)

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 6 (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 7: PHARMACY PROVIDER (Ref. 32 MRS 13761(1))

Name of Pharmacy Provider	Pharmacy License Number
Address of Pharmacy Provider	
City	State and Zip Code
Phone Number of Pharmacy Provider	
( )	

SECTION 8: CONSULTING PHARMACIST (Please see Board Rules, Chapter 14, Sec 1)

Consulting Pharmacist			
Pharmacist License Number		Expiration Date	
Contact Address	City	State	Zip Code
E-mail Address			

SECTION 9: CONTRACT (Ref. *Board Rules Chapter 9, Sec. 1(2) and Chapter 14, Section 1)*

☐ A copy of the contract between the rural health center and consulting pharmacist is enclosed

SECTION 10: HOURS OF OPERATION OF RURAL HEALTH CENTER note a.m./p.m.

Day	Open	Close
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

________ **INITIALS OF APPLICANT**

SECTION 11: THIS SECTION TO BE COMPLETED BY THE *Rural Health Center Owner or Officer*

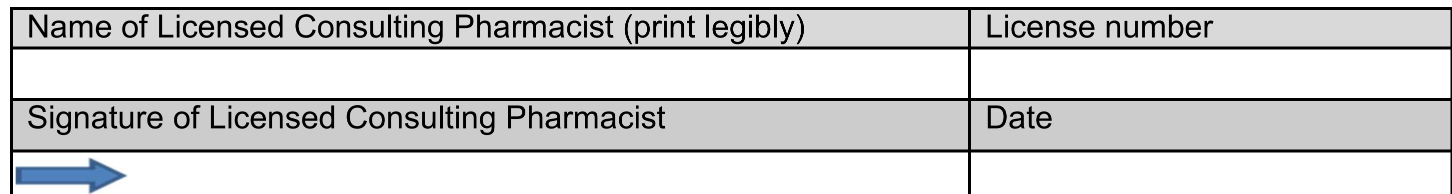
Have you or has any corporate officers, owners, or the designated officer of this entity **ever** been convicted of any criminal offense? If yes: 1. Provide a detailed explanation in the offender's own words on a separate sheet of paper. 2. Attach a copy of the Court Judgment and Decision. 3. If a motor 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. 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: **CONSULTING PHARMACIST INFORMATION** ***(Must be completed by Consulting Pharmacist)***

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.*

Question	Response
Have you, the Consulting Pharmacist, **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 Consulting Pharmacist, **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 Consulting Pharmacist, **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 Consulting Pharmacist, hold or have held, or denied your application for licensure? If yes, enclose a detailed explanation and copies of all documents.	☐ Yes ☐ No
Has the consultant pharmacist **ever** been issued a citation, warning letter or untitled letter by FDA or similar action take by any governmental board?	☐ Yes ☐ No



Name of Licensed Consulting Pharmacist (print legibly)	License number
Signature of Licensed Consulting Pharmacist	**Date**

SECTION 13: FLOOR PLAN

A. Floor Plan of Rural Health Center

Scaled drawing and floor plan 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. (See Board Rules, Chapter 9, Section 1(4))

Alert for future alteration of the prescription filling area.

Pursuant to Board Rules, Chapter 9, Section 5, a rural health center 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.

SECTION 14: STORAGE AND SECURITY

Pursuant to Board Rules, Chapter 14, Section 4, "a rural health center shall ensure the security of drugs at all times. A rural health center shall keep drugs in a locked storage area during non-business hours. A rural health center that provides pharmacy services must be protected by an alarm system."

- ☐ Submit documentation to demonstrate compliance with the storage and security requirements; or
- ☐ For good cause shown, the board may waive the storage and security requirements. Please submit your request in writing for consideration.

SECTION 15: 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**

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.

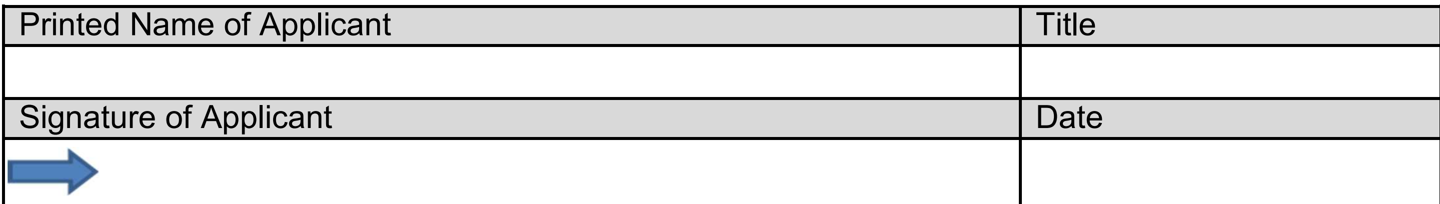
◊ Certificate of Existence from your home state

◊ Maine Certificate of Authority

SECTION 16: 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 is 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

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