



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

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION

Mailing Address: 35 State House Station, Augusta, Maine 04333 **Courier/Delivery address:** 76 Northern Avenue, Gardiner, Maine 04345 Phone: (207) 624-8603 Fax: (207) 624-8637 TTY users call Maine relay 711 web: www.maine.gov/professionallicensing

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 AM to 5:00 PM weekdays
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be emailed to you.
- **How long does it take to process an application?** You can check our website: www.maine.gov/professionallicensing. Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.

NOTICES

BACKGROUND CHECK: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Professional and Occupational Regulation requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974. Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 36 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(c)(2)(C)(i)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Sign and date your application
- Make a copy of your application to keep for your records



**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
No Fee**

Maine Pharmacy License #

PH _____

Expiration Date _____

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 (Ref. Board Rules, Chapter 7, Section 3(3))

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:

<http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html>

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.

<p>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:</p> <ol style="list-style-type: none"> <input type="checkbox"/> DEA action <input type="checkbox"/> Other State of Province (Name) _____ Submit a copy of the official action by the entity. Provide a detailed explanation in your own words on a separate sheet of paper. 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Have you, the Pharmacist in Charge, ever received a sanction from Medicare or from a state Medicaid program?</p> <ol style="list-style-type: none"> Medicare OR Medicaid Program (State) _____ Submit a copy of the official action by the entity. Provide a detailed explanation in your own words on a separate sheet of paper. <p>Clarification on programs:</p> <ul style="list-style-type: none"> 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. 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>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.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Has this entity ever been issued a citation, warning letter or untitled letter by FDA or similar action take by any governmental board?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> 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 www.maine.gov/professionallicensing—Click on “list of licensed professionals”, click on “Pharmacy” under “Board of Pharmacy Home” click on “Laws & Rules” You may also contact the following agency for federal regulations: U.S. Government Printing Office Tel (202) 512-1800, at the following web site: www.access.gpo.gov/nara/cfr/cfr-table-search.html

Notwithstanding, please pay particular attention to the following:

- 32 MRSA Chapter 117, Subchapter 5
- Board Rules, Chapter 8 & 13

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
	