





**13** Give full name and requested information for **each corporate officer, partner or member**. Check the box of the new officer. USE ADDITIONAL SHEET IF NECESSARY.

<input type="checkbox"/>	Title _____	Last four digits of their Social Security Number: <input type="text"/>
Full name _____		
Home address (street/city/state/zip) _____		
_____		
Home telephone number: _____ Licensed Pharmacist? <input type="checkbox"/> YES <input type="checkbox"/> NO License # _____		
<input type="checkbox"/>	Title _____	Last four digits of their Social Security Number: <input type="text"/>
Full name _____		
Home address (street/city/state/zip) _____		
_____		
Home telephone number: _____ Licensed Pharmacist? <input type="checkbox"/> YES <input type="checkbox"/> NO License # _____		
<input type="checkbox"/>	Title _____	Last four digits of their Social Security Number: <input type="text"/>
Full name _____		
Home address (street/city/state/zip) _____		
_____		
Home telephone number: _____ Licensed Pharmacist? <input type="checkbox"/> YES <input type="checkbox"/> NO License # _____		
<input type="checkbox"/>	Title _____	Last four digits of their Social Security Number: <input type="text"/>
Full name _____		
Home address (street/city/state/zip) _____		
_____		
Home telephone number: _____ Licensed Pharmacist? <input type="checkbox"/> YES <input type="checkbox"/> NO License # _____		

**14** a. Give full name and requested information for each **owner or principle stockholder** (owning 10% or more of corporate stock). Check the box of the new owner or stockholder. USE ADDITIONAL SHEET IF NECESSARY.

b. Is this a public owned corporation?  YES  NO. c. If this is a "not for profit" corporation, omit number 14.

<input type="checkbox"/>	Full name _____	
Home address (street/city/state/zip) _____		
_____		
Home telephone number: _____ Last four digits of their Social Security Number: <input type="text"/>		
Licensed Pharmacist? <input type="checkbox"/> YES <input type="checkbox"/> NO License # _____ # of shares owned _____ shares owned _____%		
<input type="checkbox"/>	Full name _____	
Home address (street/city/state/zip) _____		
_____		
Home telephone number: _____ Last four digits of their Social Security Number: <input type="text"/>		
Licensed Pharmacist? <input type="checkbox"/> YES <input type="checkbox"/> NO License # _____ # of shares owned _____ shares owned _____%		
<input type="checkbox"/>	Full name _____	
Home address (street/city/state/zip) _____		
_____		
Home telephone number: _____ Last four digits of their Social Security Number: <input type="text"/>		
Licensed Pharmacist? <input type="checkbox"/> YES <input type="checkbox"/> NO License # _____ # of shares owned _____ shares owned _____%		
<input type="checkbox"/>	Full name _____	
Home address (street/city/state/zip) _____		
_____		
Home telephone number: _____ Last four digits of their Social Security Number: <input type="text"/>		
Licensed Pharmacist? <input type="checkbox"/> YES <input type="checkbox"/> NO License # _____ # of shares owned _____ shares owned _____%		

**UNDER TITLE 21 OF THE CODE OF FEDERAL REGULATIONS PART 250.6: THE STATE LICENSING AUTHORITY SHALL HAVE THE RIGHT TO DENY A LICENSE TO ANY APPLICANT IF IT DETERMINES THAT THE GRANTING OF SUCH LICENSE WOULD NOT BE IN THE PUBLIC INTEREST**

**15 VAWD Accreditation**

The National Association of Boards of Pharmacy's (NABP) Verified Accredited Wholesale Distributors (VAWD) accreditation is designed to protect the public from counterfeit drugs entering the U.S. drug supply.

Has your facility obtained VAWD accreditation?

- Yes VAWD Accreditation number \_\_\_\_\_ Accreditation date \_\_\_\_\_
- No Applied for VAWD Accreditation on \_\_\_\_\_
- No Have not yet applied for VAWD Accreditation

**16 ATTESTATION OF REGISTRANT**

The undersigned affirms under penalty of perjury that the answers and statements that he/she has made in the above application are true and have been made and given with the intent of having the New York State Education Department and the New York State Board of Pharmacy rely on the truth thereof.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of registrant (Individual Owner, Partner, Corporate Officer, Member or \*Other Authorized Person)

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_  
Title

\*Power of attorney must be submitted.

**17 ATTESTATION OF SUPERVISOR- PERSON NAMED IN ITEM 8**

I hereby certify that I have full knowledge of my responsibilities and will discharge these responsibilities to the best of my ability and that I am not the supervisor of any other establishment registered by the Board of Pharmacy.

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Signature of Supervisor

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**18 Contact person to clarify information provided on this application.:**

Name: \_\_\_\_\_

Telephone: (    ) \_\_\_\_\_

Fax: (    ) \_\_\_\_\_

E-mail: \_\_\_\_\_

**NO FEE REQUIRED FOR CHANGE OF NAME  
\$170 FEE REQUIRED FOR CHANGE OF LOCATION**

**Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, Board of Pharmacy, 89 Washington Avenue, Albany, NY 12234-1000. DO NOT SEND CASH. Make check or money order payable to the New York State Education Department.**