

8

Names of ALL pharmacists including the supervising pharmacist, and of pharmacy interns, as printed on original licenses, or permits, practicing in this pharmacy. (Use additional sheets if necessary.)	Social Security Number	Hours worked each week	Pharmacist License No. or Permit No.	Original date of issue

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Check all that apply:

Is this location also registered as a: pharmacy manufacturer wholesaler repacker

If yes, Name: _____ Registration number: _____

Does the applicant, individual owner, partner, officer or principal stockholder have financial or ownership interest in any New York State registered: pharmacy manufacturer wholesaler repacker

If yes, list any/all registered pharmacy/manufacturer/wholesaler/repacker that the applicant, individual owner, partner, officer or principal stockholder has interest in. (Attach a list if necessary.)

_____ Registration number: _____

_____ Registration number: _____

_____ Registration number: _____

10

(a) How many hours per week is this establishment open for business? _____

(b) How many hours per week does the supervising pharmacist work at this establishment? _____

11

Has the applicant, or any individual owner or partner in a partnership, or any officer, director or principle stockholder in a corporation ever been known by any other name(s)? YES NO

If Yes, indicate such former name or names and reason for changing. _____

12

MORAL CHARACTER

The following questions pertain to any owner or corporate officer of the establishment or registrant.

(a) Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? YES NO

(b) Are criminal charges pending against you in any court? YES NO

(c) Has any licensing or disciplinary authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a professional license or certificate held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you? YES NO

(d) Are charges pending against you in any jurisdiction for any sort of professional misconduct? YES NO

(e) Have you ever willfully failed to provide records to any State Licensing authority or to Federal, State or Local law enforcement officials that are required by Federal, State or Local laws? YES NO

If yes, please explain _____

(f) Has any hospital or licensed facility restricted or terminated your professional training, employment, or privileges or have you ever voluntarily or involuntarily resigned or withdrawn from such association to avoid imposition of such measures? YES NO

NOTE: If you answer "Yes" to any questions (a) through (f), submit a letter giving complete explanation. Include copies of any court records, and if you possess one, a copy of the "Certificate of Relief from Disabilities" or your "Certificate of Good Conduct."

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

Title _____ Last four digits of their Social Security Number:

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Licensed Pharmacist? YES NO License # _____

Title _____ Last four digits of their Social Security Number:

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Licensed Pharmacist? YES NO License # _____

Title _____ Last four digits of their Social Security Number:

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Licensed Pharmacist? YES NO License # _____

Title _____ Last four digits of their Social Security Number:

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Licensed Pharmacist? YES 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 newest owner or stockholder. USE ADDITIONAL SHEETS IF NECESSARY.

b. Is this a public owned corporation? YES NO. c. Not-for-Profit entity **DO NOT COMPLETE THIS SECTION.**

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Last four digits of their Social Security Number:

Licensed Pharmacist? YES NO License # _____ # of shares owned _____ shares owned _____%

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Last four digits of their Social Security Number:

Licensed Pharmacist? YES NO License # _____ # of shares owned _____ shares owned _____%

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Last four digits of their Social Security Number:

Licensed Pharmacist? YES NO License # _____ # of shares owned _____ shares owned _____%

Full name _____

Home address (street/city/state/zip) _____

Home telephone number: _____ Last four digits of their Social Security Number:

Licensed Pharmacist? YES NO License # _____ # of shares owned _____ shares owned _____%

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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) _____ (title)

Signature of registrant _____ Date ____ / ____ / ____
(Individual Owner, Partner, Corporate Officer, Member or *Other Authorized Person) mo. day yr.

*Power of attorney must be submitted.

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ATTESTATION OF SUPERVISING PHARMACIST – PERSON NAMED IN ITEM 6

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 supervising pharmacist of any other establishment registered by the Board of Pharmacy.

_____ (print name)

Signature of supervising pharmacist _____

Date ____ / ____ / ____
mo. day yr.

To assure prompt filing, please be sure you have completed all portions of this **APPLICATION** and send it with a fee of **\$345** to:

New York State Education Department
Board of Pharmacy
89 Washington Avenue
Albany, NY 12234-1000

Note: Please make check or money order payable to the “**New York State Education Department**”. Payments made outside the United States should be made payable by check or draft on a United States bank in U.S. currency.