The University of the State of New York  
THE STATE EDUCATION DEPARTMENT  
Office of the Professions  
New York State Board of Pharmacy  
89 Washington Avenue  
Albany, NY 12234-1000  
Phone: 518-474-3817 ext. 130  
E-mail: pharmbd@nysed.gov  

NON-RESIDENT  
NOTICE OF CHANGE IN OFFICERS  
AND/OR OWNERSHIP  

The Pharmacy Board must be notified within 30 days of any change in  
ownership or officers – Regulations of the Commissioner 63.6(a)(3).  

1
Type of establishment (check one)  
☐ Pharmacy  
☐ Repacker Medicinal Gases  
☐ Manufacturer  
☐ Repacker  
☐ Wholesaler/Distributor

2
a. Name of establishment (as registered):  
b. Registration number:  
c. Address:  
d. Phone: _________________________ Fax: _________________________ E-mail address: _________________________

3
Give full name and title for each corporate officer, partner, member or owner. Check the box of the new officer, provide signature for new officer(s).  
USE ADDITIONAL SHEETS IF NECESSARY.

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<tr>
<th>Last Name, First Name (please print)</th>
<th>Signature of New Owner or Officer</th>
<th>Date</th>
<th>Title (please print)</th>
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Form OOS 522, Page 1 of 2, (Rev. 10/07)
Contact person to clarify information provided on this application:

Name: __________________________________________________________________________________
Telephone: ______________________________________________
Fax: ___________________________________________________
E-mail: _________________________________________________________________________________

ATTESTATION  (Notarization required.)

REGISTRANT
The undersigned affirms under penalty of perjury that the answers and statements that he/she has made in the above application are true.

Print Name: ____________________________________________________________________________
Title: ________________________________________________________________________________

Signature of Registrant: ____________________________________________ Date: _______ / _______ / _______
(Individual Owner, Partner, Corporate Officer, or *Other Authorized Person) Month Day Year

*Power of attorney must be submitted

NOTARY
State of __________________________________________ County of _______________________________________
On the ____________ day of ______________________ in the year __________, before me personally appeared the
above registrant ____________________________________________, personally known to me or proved to me on
the basis of satisfactory evidence to be the individual whose name is subscribed to this application, and acknowledged
to me that he/she executed the application and swore that the statements made by him/her in the application and all
supporting materials are true, complete, and correct 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.

Notary Public signature ___________________________________________________________________________

Notary Commission Expires: _______ / _______ / _______
Month Day Year

Notary Stamp