





**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.

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 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.

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 \_\_\_\_\_%

**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**

**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.

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

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

\_\_\_\_\_  
Title

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr.

\*Power of attorney must be submitted.

**17**

**ATTESTATION OF SUPERVISING PHARMACIST**

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.

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

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

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
mo. day yr.

**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, State 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.