The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
State Board of Pharmacy
www.op.nysed.gov/pharm/

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 ☐ Manufacturer ☐ Repacker

☐ Repacker Medicinal Gases ☐ Wholesaler/distributor ☐ Outsourcing Facility

2

a. Name of establishment (as registered): ______________________________

b. Registration number: ______________________________

c. Address: ______________________________

____

d. Phone: ______________ Fax: ______________ E-mail address: ______________

3 Name of present supervisor – refer to displayed registration: ______________________________

4 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. A copy of current driver's license or passport is required for each new owner/officer/partner.

Effective date: ________ / ________ / ________
mo. day yr.

☐ 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 # ______________

5

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. A copy of current driver's license or passport is required for each new owner/officer/partner.

Effective Date: _______ / _______ / _______
mo. day yr.

☐ 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 __________%

6

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: __________

______________________________ Registration number: __________

______________________________ Registration number: __________

______________________________ Registration number: __________

7 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."

8 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

Return this completed form to: New York State Education Department, Office of the Professions, State Board of Pharmacy, 89 Washington Avenue, Albany, NY 12234-1000