**APPLICATION FOR INITIAL REGISTRATION OR TRANSFER OF OWNERSHIP OF PHARMACY**

Please print legibly or type

1. **Name under which registration is sought**

   |   |   |   |   |   |   |   |   |   |   |   |
   |   |   |   |   |   |   |   |   |   |   |   |

2. **Address**

   Street and Number: __________________________

   City: __________________________

   State: __________________________

   County: __________________________

   Zip Code: __________________________

3. **If a transfer of ownership, under what name is this establishment currently registered?**

   Registration number: __________________________

   Date of proposed transfer: ________ / ________ / ________

4. **Trade name or assumed name of firm, if any. (Only assumed names registered with the County Clerk or New York State Department of State are acceptable).**

5. **(a) Please indicate type of ownership:**

   |   |   |   |   |   |
   |   |   |   |   |   |

   (b) County: __________________________

   (c) Telephone: __________________________

   (d) Fax: __________________________

   (e) E-mail: __________________________

   (f) Federal Employer ID#: __________________________

6. **Name the supervising pharmacist who will be responsible for the supervision of the activities to be conducted by the registrant.**

   Name of supervising pharmacist: __________________________

   Pharmacist License number: __________________________

   Date of licensure: ________ / ________ / ________

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

   Name: __________________________

   Phone: __________________________

   Fax: __________________________

   E-mail address: __________________________

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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.)

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Hours worked each week</th>
<th>Pharmacist License No. or Permit No.</th>
<th>Original date of issue</th>
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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: _______________________

(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? ____________________________

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. ____________________________________________________________

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?

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.”

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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: ____________________________ Licensed Pharmacist?  ☐ YES  ☐ NO  License # ______ # of shares owned ______ shares owned ______%

☐ Full name ____________________________________________

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

  Home telephone number: ____________________________ Licensed Pharmacist?  ☐ YES  ☐ NO  License # ______ # of shares owned ______ shares owned ______%

☐ Full name ____________________________________________

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

  Home telephone number: ____________________________ Licensed Pharmacist?  ☐ YES  ☐ NO  License # ______ # of shares owned ______ shares owned ______%
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.

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.