Lawrence H. Mokhiber
Executive Secretary

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of the Professions
New York State Board of Pharmacy
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Department Use Only

☐ | **P 1** | **$345** | **I R**

Registration Number: ____________

Registered as of: ____ / ____ / ____

Approved: ____________________

Date: ____ / ____ / ____

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:**

☐ Individual
☐ Government Owned
☐ Corporation for profit
☐ Corporation not-for-profit
☐ LLC for profit
☐ LLC not-for-profit
☐ Partnership/LLP for profit
☐ Partnership/LLP not-for-profit

(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: ____

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. ______________

____

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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.