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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Albany, NY 12234-1000
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Department Use Only

☐ P 1 $ 5 0 R E

APPLICATION FOR **ENDORSEMENT** OF REGISTRATION OF PHARMACY

PLEASE PRINT LEGIBLY OR TYPE

This form may be used only for change of location and change of name authorized by the New York State Department of State

Registration Number: _____

Current Registered Period: _____

Date of Endorsement: _____

Staff Processor: _____

Approved: _____

Date: _____

1 **Name under which registration has been issued or sought**

2 **Previous Address** Street and Number

City

State County

Zip Code

New Address Street and Number

City

State County

Zip Code

3 If a change in name, under what name is this establishment currently registered? Examine the registration certificate. Registration number _____

_____ Date: _____ / _____ / _____

4
☐ Address change: _____ Date: _____ / _____ / _____
☐ Address change due to fire: Temporary_____ Permanent _____
☐ Other (explain) _____

5 Trade name or assumed name of firm, if any. (Only assumed names registered with the New York State Department of State).

_____

6 (a) Check type of ownership

☐ INDIVIDUAL
☐ PARTNERSHIP (FOR PROFIT)
☐ PARTNERSHIP (NOT FOR PROFIT)
☐ LLC (FOR PROFIT)
☐ LLC (NOT FOR PROFIT)
☐ GOVERNMENT INSTITUTION
☐ CORPORATION (FOR PROFIT)
☐ CORPORATION (NOT FOR PROFIT)

(b) County _____

(c) Telephone _____

(d) Fax _____

(e) E-mail _____

(f) Federal Employer. ID# _____

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

Name of supervising pharmacist _____

Social Security Number: ___-___-____ Date of birth _____ / _____ / _____

Pharmacist License number _____ Date of licensure _____ / _____ / _____

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

9 Are the licenses and registrations of all pharmacists (owners and employees) and the permits of all the interns practicing in this pharmacy conspicuously displayed in this pharmacy?

If No, why not? _____

10 Check all that apply:

Is this location also registered as a: ☐ pharmacy ☐ manufacturer ☐ wholesaler ☐ repacker

If yes, Name: _____

Does the applicant, individual owner, partner, officer or principle 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 principle stockholder has interest in. (Attach a list if necessary.)

_____ Registration number: _____

_____ Registration number: _____

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)?

If Yes, indicate such former name or names and reason for changing. _____

_____

12

(a) For how many hours per week is the establishment open for business? _____

(b) How many hours per week does the supervising pharmacist work at this establishment? _____

13 **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."

14 Give full name and requested information for **each corporate officer, partner or member**. Check the box of the new officer. USE ADDITIONAL SHEET IF NCESSARY.

☐ 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 # ____________________

15 **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 15.

☐ 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)

*Power of attorney must be submitted.

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ATTESTATION OF SUPERVISING PHARMACIST – PERSON NAMED IN ITEM 7

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 _____ / _____ / _____

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Contact person to clarify information provided on this application.:

Name: _____

Telephone: ( ) _____

Fax: ( ) _____

E-mail: _____

NO FEE REQUIRED FOR CHANGE OF NAME

$50 FEE REQUIRED FOR CHANGE OF LOCATION

Mail this form and appropriate fee to: New York State Education Department, Office of the Professions, 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.