



STATE OF MAINE BOARD OF PHARMACY

Application and applicant information to assist in completing your application

Mail Order Pharmacy

READ THIS CAREFULLY

Filing an application does not constitute approval to begin to ship drugs into Maine.
You must have an active license before you ship to Maine.

Please do not submit a partially completed application, including failure to submit all required supporting documents, your application will not be accepted and will be returned. Fees are nonrefundable, including applications that are incomplete. You will be required to submit a new application together with the Fee. Only fully completed applications will be accepted.

Department of Professional and Financial Regulation
Office of Professional and Occupational Regulation
(Mailing address) 35 State House Station, Augusta, ME 04333
(Office location) Gardiner Annex, 76 Northern Avenue, Gardiner, Maine 04345

Office Direct Line (207) 624-8620 or Main Receptionist (207) 624-8603
TTY/Hearing Impaired 1-888-577-6690
FAX (207) 624-8637

Web address: www.maine.gov/professionallicensing
Email: pharmacy.lic@maine.gov

INFORMATIONAL

- ✓ Receipt of your application does not constitute entitlement to begin to ship into Maine. While applications are logged in as 'pending' this does not mean a license has been issued. You must hold an active license in order to begin shipping into Maine. Processing time depends greatly on the completeness of your application.

- ✓ Please do not call our office regarding the status of your application as numerous calls will delay the timeliness of processing applications. Information regarding the status of applications may be found at the Office of Professional and Occupational Regulation's website www.maine.gov/professionallicensing. We appreciate your thoughtful attention to this request.

- ✓ If there is an urgent need to contact us, please be advised that we will only discuss your application with the contact person named in the application to avoid miscommunications. This is done not only for your protection, but to also avoid any complications with too many hands involved, which generally leads to miscommunication or misunderstandings. Our goal is to streamline your process, not complicate it.

- ✓ Once your license is issued it is immediately visible online with an "active" status and you may begin to operate. Please be advised that licenses are printed off site and require at least 14 business days for delivery.

- ✓ Incomplete applications or documents that have been modified or altered in any way, including use of a white out substance will not be accepted and will be returned.

- ✓ Pursuant to 32 MRS § 13752 (2)(C) the pharmacist in charge that is "the" named pharmacist in charge for a mail order pharmacy must be the same pharmacist in charge named for the Mail Order Pharmacy license in the state that the pharmacy is physically located.

LAW AND BOARD RULE REFERENCE

Information contained in this application is not a substitute for carefully reviewing applicable laws and rules. You may obtain a copy of the laws and board rules online at www.maine.gov/professionallicensing—click on 'professions and occupations' then scroll to and click on 'pharmacy' which will bring you to the Board of Pharmacy web page. Please use the topic selection grouping in the blue panel to the right of your screen.

Notwithstanding, please pay particular attention to the following:

- 32 MRSA c. 117, Subchapter 5
- Board Rules, Chapter 11

STATE OF MAINE DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION

Mailing Address: 35 State House Station, Augusta, Maine 04333 **Courier/Delivery address:** 76 Northern Avenue, Gardiner, Maine 04345
Phone: (207) 624-8603 Fax: (207) 624-8637 Hearing Impaired: (888) 577-6690 web: www.maine.gov/professionallicensing

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 35 State House Station, Augusta, Maine 04333-0035
- **Where are you located?** 76 Northern Avenue, Gardiner, Maine.
- **What hours are you open?** 8:00 AM to 5:00 PM weekdays
- **Can I come to Gardiner to drop off my application?** Yes. You will not leave with a license, though.
- **Can I come to Gardiner to pick up my license?** No. Your license will be mailed to you.
- **How long does it take to process an application?** You can check our website: www.maine.gov/professionallicensing. Your license will show up as PENDING at first; as soon as your status is ACTIVE you are authorized to practice.
- **How far back do I go answering the criminal question?** Any conviction, ever.

NOTICES

BACKGROUND CHECK: Pursuant to 5 MRS §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Office of Professional and Occupational Regulation requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRS §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRS §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(1)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Before you seal the envelope, did you:

- Complete every item on the application (incomplete applications may be returned)
- Answer the criminal background disclosure questions
- Sign and date your application
- Include correct amount (payable to Maine State Treasurer) or credit card information (plus signature)
- Include any required transcripts or exam results
- Make a copy of your application to keep for your records
- DO NOT SEND CASH.



**STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
OFFICE OF PROFESSIONAL AND OCCUPATIONAL REGULATION
COMPANY APPLICATION**

APPLICANT INFORMATION (please print)			
NAME OF MAIL ORDER PHARMACY			
FEIN OR SSN			
PHYSICAL LOCATION OF THE MAIL ORDER PHARMACY			
CITY	STATE	ZIP	COUNTY
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ()		FAX # ()	
PERSON RESPONSIBLE FOR COMPLETING AND SUBMITTING APPLICATION (must be an owner or officer of the entity)			
By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.			
SIGNATURE		DATE	

**Board of Pharmacy
Mail Order Pharmacy
Required Fee: \$200.00 (Non Refundable)**

Office Use Only:
MO1421 - \$200.00

Office Use Only:
Check # _____
Amount: _____
Cash # _____
Lic. # _____
Issue Date _____
Exp. Date _____

PAYMENT OPTIONS:	
Make checks payable to "Maine State Treasurer" - If you wish to pay by Mastercard or Visa, fill out the following:	
NAME OF CARDHOLDER (please print name on card)	
I authorize the Department of Professional and Financial Regulation, Office of Professional and Occupational Regulation to charge my <input type="checkbox"/> VISA <input type="checkbox"/> MASTERCARD the following amount: \$ _____	
Card number:	Expiration Date /
SIGNATURE	DATE

SECTION 4: HOURS OF OPERATION WHICH A PHARMACIST WILL BE AVAILABLE VIA TOLL FREE TELEPHONE - note a.m./ p.m.

Toll-Free Telephone Public Access # _____

Day	Open	Close
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

SECTION 5: OWNERSHIP. Please check one and complete the appropriate block below.

- Sole Proprietor (*complete section A*)
- Partnership (*complete section B*) - If your partnership consists of 2 corporations or more, you must submit a list of officers and an organizational chart.
- Corporation (*complete section C*) - If you are a corporation, which includes LLC, you must submit a Certificate of Existence from the State of origin. For Corporations not organized under Maine law, a Certificate of Authority from the Maine Secretary of State is required. For assistance, call (207) 624-7752. Please be aware the application to file for a certificate of existence is not evidence of having been issued a Certificate of Authority.

Section A - Sole Proprietor: (Please type or print legibly)			
Owner Last Name	First Name	Middle Name	
Social Security Number			
Name of Business Entity			
Contact Address	City	State	Zip Code
Telephone Number	Fax Number		
()	()		
E-mail Address Website Address			

INITIALS OF APPLICANT

SECTION 5: CONTINUED

Section B - Partnership: List the name and address of each partner (please type or print legibly).
Please see Chapter 11, Sec. 1(1)(D)(1)) (If you need more space please use separate sheet)

PARTNERSHIP INFORMATION:

Name of partnership			
Contact Address	City	State	Zip Code
Telephone Number		FEIN Number	
()			
E-mail Address			

NAME AND CONTACT INFORMATION OF EACH PARTNER

Person Last Name	First Name	Middle Name	
Contact Address	City	State	Zip Code
E-mail Address		Telephone number	
		()	

Person Last Name	First Name	Middle Name	
Contact Address	City	State	Zip Code
E-mail Address		Telephone number	
		()	

Company Name			FEIN Number
Contact Address	City	State	Zip Code
E-mail Address		Telephone number	
		()	

Company Name			FEIN Number
Contact Address	City	State	Zip Code
E-mail Address		Telephone number	
		()	

_____ INITIALS OF APPLICANT

SECTION 5 (Continued):

Section C - Corporation Ownership: Please include an organizational chart. (Please type or print legibly) <i>Please see Chapter 11, Sec. 1(1)(D)(2))</i>			
Name of Corporation			
Assumed Name (d/b/a)			
Name of Parent Company, if any			
FEIN #			
Contact Address of Corporation	City	State	Zip Code
Physical Address of Corporation	City	State	Zip Code
Telephone Number		Fax Number	
()			
E-mail Address		Website Address	
Corporate Registration Certificate Number	Issued Under What Jurisdiction	Date	
Contact Address for Registered Agent <i>If different from Corporation</i>	City	State	Zip Code
Physical Address for Registered Agent <i>If different from Corporation</i>	City	State	Zip Code
Telephone Number	E-mail Address/ Website Address		
()			

INITIALS OF APPLICANT

SECTION 5-C (Con't): CORPORATION OWNERSHIP Please see *Chapter 11, Sec. 1(1)(D)(2)*

Is this corporation's stock traded on a major stock exchange and not over-the-counter

YES

NO

If, no complete the section below—List the name and contact address of each shareholder owning 10% or more of the voting stock of the corporation, including over-the-counter stock. Use a separate sheet of paper if needed.

1. Last Name		First Name		Middle Name	
Address		City		State	Zip Code
E-mail Address			Telephone Number		
			()		
2. Last Name		First Name		Middle Name	
Address		City		State	Zip Code
E-mail Address			Telephone Number		
			()		
3. Last Name		First Name		Middle Name	
Address		City		State	Zip Code
E-mail Address			Telephone Number		
			()		
4. Last Name		First Name		Middle Name	
Address		City		State	Zip Code
E-mail Address			Telephone Number		
			()		

INITIALS OF APPLICANT

SECTION 5-C (Con't): CORPORATE OFFICER(S) AND DIRECTOR

1. Last Name	First Name	Middle Name	
Title			
Address	City	State	Zip Code

2. Last Name	First Name	Middle Name	
Title			
Address	City	State	Zip Code

3. Last Name	First Name	Middle Name	
Title			
Address	City	State	Zip Code

4. Last Name	First Name	Middle Name	
Title			
Address	City	State	Zip Code

INITIALS OF APPLICANT

SECTION 6: THIS SECTION TO BE COMPLETED BY THE MAIL ORDER PHARMACY OWNER OR OFFICER

<p>Have you or has any corporate officers, owners, or the designated officer of this entity been convicted of any criminal offense? If yes:</p> <ol style="list-style-type: none">1. Provide a <u>detailed explanation</u> in the offender's own words on a separate sheet of paper.2. Attach a copy of the <u>Court Judgment and Decision</u>.3. If a motor vehicle criminal offense, attach a copy of a recent motor vehicle report.	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Has any state or territory of the U.S., province/territory of Canada, or any other jurisdiction EVER denied your application for any type of examination, professional license, certificate or registration, or taken any disciplinary action against the license issued to you in that jurisdiction (including, but not limited to, warning, reprimand, fine, suspension, revocation or restrictions in permitted practice, probation with or without monitoring)? If yes:</p> <ol style="list-style-type: none">1. List the jurisdiction(s) that denied your license or issued discipline and date of action: State/Jurisdiction _____ Date _____ State/Jurisdiction _____ Date _____2. Submit a copy of the consent agreement or decision and order for each of the above.3. Provide a detailed explanation in your own words on a separate sheet of paper.	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Has <u>this entity</u> ever been denied registration by the U.S. Drug Enforcement Administration (DEA) or has this entity ever had a DEA Registration modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked this entity's state permit to prescribe or dispense controlled substances? If yes:</p> <ol style="list-style-type: none">1. DEA action <u>OR</u> Other Entity (Name) _____2. Submit a copy of the official action by the entity.3. Provide a detailed explanation in your own words on a separate sheet of paper.	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

INITIALS OF APPLICANT

SECTION 7: LIST OF JURISDICTIONS IN WHICH YOU HOLD OR HAVE EVER HELD A PHARMACEUTICAL LICENSE.

On a separate sheet, list each state or jurisdiction the applicant has at any time held a pharmaceutical license, including controlled substance licenses.

The information must include the following:

State, Territory, Country	License Number & Lic Type	Date Issued	Expiration Date	Was discipline ever imposed? Yes / No
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Optional: For your convenience a form to report this information is available online from our applications and forms section entitled "Reporting Jurisdictions of Licensure."

If discipline was imposed, you must submit a copy of the consent agreement or order issued by the Board.

SECTION 8: NOTICES

Social Security Number Disclosure

The following statement is made pursuant to the Privacy Act of 1974 section 7 (B). Disclosure of your social security number is mandatory. Solicitation of your social security number is solely for tax administration purposes pursuant to 36 MRS section 175 as authorized by the Tax Reform Act of 1976 (42 USC section-405 (C) (2) (1)). Your social security number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your social security number and it shall be treated as confidential tax information pursuant to 36 MRS §191.

Notice to Consumers (Board Rule Chapter 11, Section 5)

A mail order prescription pharmacy shall include with each prescription filled prominent notice that complaints against the mail order prescription pharmacy may be filed with the Complaint Coordinator, Office of Professional and Occupational Regulation, 35 State House Station, Augusta, ME 04333.

INITIALS OF APPLICANT

SECTION 8—Con't: NOTICES

10 Day Notification Requirement

This applicant/licensee must report in writing to the Board the following information no later than 10 days after the change or event, as the case may be:

- a. Change of name or address of the licensee;
- b. A criminal conviction of the licensee or anyone listed on this application as having an ownership interest in the licensee;
- c. A revocation, suspension, or other disciplinary action taken in this or any other jurisdiction against any occupational or professional license held by the applicant/licensee or anyone listed on this application as having an ownership interest in the licensee; or
- d. Any material change in the conditions or qualifications set forth in the original application for licensure submitted to the Board.

SECTION 9: PHARMACIST IN CHARGE INFORMATION (32 MRSA §13702-A (23) "Pharmacist in charge means the pharmacist who is responsible for the licensing of the pharmacy," and the contact person for this office for licensing the mail order pharmacy.)

Last Name		First Name		Middle	
Contact Address					
City		State		Zip Code	
Telephone Number			E-mail Address		
License Number:		State Issued		License Expiration Date:	

INITIALS OF APPLICANT

SECTION 9: Con't PHARMACIST IN CHARGE INFORMATION

THIS SECTION MUST BE COMPLETED BY THE PHARMACIST IN CHARGE (“PIC”). Check appropriate response to the questions below. Any YES response must be fully explained by written statement on a separate sheet of paper, signed and dated, and submitted with your application. **CRIMINAL BACKGROUND DISCLOSURE** *NOTE: Failure to disclose criminal convictions may result in denial, fines, suspension and/or revocation of a license.*

<p>Have you, the Pharmacist in Charge, ever been denied registration by the U.S. Drug Enforcement Administration (DEA) or has this entity ever had a DEA Registration modified, restricted, suspended or revoked? Has any state or province denied, restricted, modified, suspended or revoked this entities state permit to prescribe or dispense controlled substances? If yes:</p> <ol style="list-style-type: none"> 1. DEA action or Other Entity (Name) _____ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper. 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Have you, the Pharmacist in Charge, ever received a sanction from Medicare or from a state Medicaid program?</p> <ol style="list-style-type: none"> 1. Medicare OR Medicaid Program (State) _____ 2. Submit a copy of the official action by the entity. 3. Provide a detailed explanation in your own words on a separate sheet of paper. <p>Clarification on programs:</p> <ul style="list-style-type: none"> • Medicare – Health program administered by the United States government for people that are (1) ages 65 or older, (2) under the age of 65 with certain disabilities, and/or (3) all ages with end-stage renal disease. • Medicaid – Health program administered by the United States government for people with limited incomes. • MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid. 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Have you, the Pharmacist in Charge, ever been convicted by any court of any crime? If yes, enclose a detailed description of what happened (including dates) and a copy of the court judgment.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Has any jurisdiction taken disciplinary action against any professional license you, the Pharmacist in Charge, hold or have held, or denied your application for licensure? If yes, enclose a detailed explanation and copies of all documents.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

INITIALS OF APPLICANT

SECTION 9: Con't PHARMACIST IN CHARGE INFORMATION

Read the statement below and sign where indicated as your certification of the information provided on this application.

As the Pharmacist in Charge I certify by my signature that I have read and understand the Maine Board of Pharmacy laws and rules and related laws and rules as it applies to Mail Order Pharmacy. I also certify that the management of the pharmacy will be vested with the pharmacist in charge in all matters directly or indirectly related to the practice of pharmacy or in any matters related to health, welfare, and safety of the public, as required by laws and rules.

Printed Name of PIC	
Signature of PIC	Date

MAIL ORDER PHARMACY—Checklist affirmation

Please check mark each box to affirm that you have enclosed the information and documents required for this application. This affirmation checklist does not replace the requirements outlined in the Board of Pharmacy Laws and Rules. Please review them carefully for more detailed and clarifying information. This checklist is designed as a tool to confirm that your application is complete and ready to forward to our office.

CHECKLIST—please checkmark as an indicator that you have completed the following.

- Each section of the application has been completed.
- Each page of the application, where noted, has been initialed.
- Signature present where noted.
- Check made payable to: Treasurer State of Maine in the amount of \$200.00 is enclosed, or Credit card authorization completed.
- Most recent inspection report from the state in which this facility is located. If the state board or jurisdiction does not conduct inspections of the facility, check here **and** submit with this application a confirmation statement from the state board or jurisdiction.
- Company's organizational chart.
- You must disclose all states in which you hold or have held a license and sign an affirmation statement to this effect.
- A copy of the consent agreement or order issued by the Board or jurisdiction is enclosed if licensure discipline has been indicated.
- A copy of the Court Judgment and Decision is enclosed if convicted of a crime, including a written statement, in your words, regarding the details of the crime.
- If you are a corporation, which includes LLC, you must submit a Certificate of Existence from the State of origin. For Corporations not organized under Maine law, a Certificate of Authority from the Maine Secretary of State is required (see sample attached). For assistance, call (207) 624-7752. Please be aware the application to file for a certificate of existence is not evidence of having been issued a Certificate of Existence.
- DEA number. If not applicable, you must submit a written statement.

SECTION 8: APPLICANT'S CERTIFICATION AND SIGNATURE

Read the statement below and sign where indicated as your certification of the information provided on this application.

By my signature, I hereby certify that the information provided on this application and in accompanying documents is true and accurate to the best of my knowledge and belief. By submitting this application I understand that the Maine Board of Pharmacy will rely upon this information for issuance of my license and that this information is truthful and factual. I affirm that I have provided an accurate list of all states in which I hold or have ever held a pharmaceutical license and any disciplinary action taken in another state of jurisdiction. I further understand that sanctions may be imposed, including denial, suspension or revocation of my license, if this information is found to be false. I also acknowledge that an incomplete, altered, defaced, including use of white out, or compromised application will not be accepted and will be returned and fees forfeited. This includes, but not limited to, unanswered questions, lack of appropriate signature, illegible, missing supporting documents, and/or missing or wrong fee.

Printed Name of Applicant	Title
Signature of Applicant	Date
Signature of PIC	Date