



# STATE OF MAINE BOARD OF PHARMACY

**Application and applicant information to assist  
in completing your application**

## Pharmacy **Change of Pharmacist in Charge For A Licensed Pharmacy Located in the State of Maine**

**READ THIS CAREFULLY**

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](http://www.maine.gov/professionallicensing)  
Email: [pharmacy.lic@maine.gov](mailto:pharmacy.lic@maine.gov)

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](http://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](http://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 PHARMACY			
FEIN OR SSN			
PHYSICAL LOCATION OF THE PHARMACY			
CITY	STATE	ZIP	COUNTY
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # (    )		FAX # (    )	
PERSON RESPONSIBLE FOR COMPLETING AND SUBMITTING APPLICATION			
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.			
<b>SIGNATURE</b>		<b>DATE</b>	

<h2 style="margin: 0;">Board of Pharmacy</h2> <h3 style="margin: 0;">Change of Pharmacist in Charge</h3> <p style="margin: 0;">for a Licensed Pharmacy Located in the State of Maine</p> <p style="margin: 0;">Required Fee: \$100.00 (Non Refundable)</p>		
Maine Pharmacy License #  PH _____  Expiration Date _____	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 0 auto;"><i>Office Use Only:</i>  1457 - \$100.00</div>	<div style="border: 1px solid black; padding: 5px;"><i>Office Use Only:</i> Check # _____ Amount: _____ Cash # _____ Lic. # _____ Issue Date _____ Exp. Date _____</div>

<b>PAYMENT OPTIONS:</b> 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 _____ / _____
<b>SIGNATURE</b>	<b>DATE</b>

**SECTION 1: COMPANY INFORMATION**

<b>Name of Pharmacy</b>	
<b>Pharmacy Telephone Number</b>	<b>Pharmacy Fax Number</b>
(     )	(     )
<b>E-mail Address</b>	
<b>Web Address</b>	<b>DEA #</b>
<b>All Trade Names or Business Names of the Pharmacy</b>	

**SECTION 2: PHARMACIST IN CHARGE INFORMATION** (32 MRSA §13702-A (23)) *“Pharmacist in charge means the pharmacist who is responsible for the licensing of the pharmacy,”*  
**THE BOARD OF PHARMACY HOLDS THE PIC RESPONSIBLE FOR ALL PHARMACY RELATED MATTERS.**

<b>Pharmacist in Charge Name</b>			
<b>Pharmacist License Number</b>		<b>Expiration Date</b>	
<b>Contact Address of PIC</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>E-mail Address</b>			

**SECTION 3: EFFECTIVE DATE OF CHANGE**

<b>Effective date you, the pharmacist in charge, will take over as PIC</b>

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INITIALS OF PIC

**SECTION 4: PHARMACY TECHNICIAN REPORT (Ref. Board Rules, Chapter 7, Section 3(3))**

Please list all pharmacy technicians\* employed at the pharmacy. (Use separate sheet if necessary)

\*This applies to pharmacy technicians who are properly registered with the Maine Board of Pharmacy as Pharmacy Technician, Pharmacy Technician Intern, or Pharmacy Technician Advanced. Please make extra copies of the page for additional employees.

1. Pharmacy Technicians Name	License Number	Expiration Date
2. Pharmacy Technicians Name	License Number	Expiration Date
3. Pharmacy Technicians Name	License Number	Expiration Date
4. Pharmacy Technicians Name	License Number	Expiration Date
5. Pharmacy Technicians Name	License Number	Expiration Date
6. Pharmacy Technicians Name	License Number	Expiration Date

**SECTION 5: DESIGNATION OF AUTHORIZED PERSONS (See Ref. Board Rule, Ch. 1, Sec. 1)**

<b>1. First Name</b>	<b>MI</b>	<b>Last Name</b>	<b>Date of Birth</b>
Contact Address		Street or P.O. Box	
City	State	Zip Code	County
Position Title		Purpose	
<b>2. First Name</b>	<b>MI</b>	<b>Last Name</b>	<b>Date of Birth</b>
Contact Address		Street or P.O. Box	
City	State	Zip Code	County
Position Title		Purpose	

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INITIALS OF PIC

**SECTION 6: DESIGNATION OF AUTHORIZED PHARMACY TECHNICIANS**  
(See Ref. Board Rule, Ch. 1, Sec. 2)

Name	License Number
Name	License Number
Name	License Number

**SECTION 7: THIS SECTION APPLIES ONLY TO WAIVER REQUEST(S) (requirements listed in Board Rules Chapter 8 sec. 2):**

Please check all that apply and attached a letter to demonstrate good cause for waiver requested.

- Minimum 40 hours per week of operation
- Practice by the pharmacist in charge at the drug outlet for which he or she has registered for a minimum of 30 hours per week or 50% of the hours that the pharmacy is open, whichever is less.

**SECTION 8: 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.

**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.

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INITIALS OF PIC

## **SECTION 9: PHARMACIST IN CHARGE INFORMATION**

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"> <li>1. DEA action or Other Entity (Name) _____</li> <li>2. Submit a copy of the official action by the entity.</li> <li>3. Provide a detailed explanation in your own words on a separate sheet of paper.</li> </ol>	<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"> <li>1. Medicare OR Medicaid Program (State) _____</li> <li>2. Submit a copy of the official action by the entity.</li> <li>3. Provide a detailed explanation in your own words on a separate sheet of paper.</li> </ol> <p>Clarification on programs:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Medicaid – Health program administered by the United States government for people with limited incomes.</li> <li>• MaineCare – Health program administered by the State of Maine with similar eligibility requirements as Medicaid.</li> </ul>	<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 consent agreement or board order.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

## **SECTION 10: LAWS AND RULES 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](http://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 8 & 13

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INITIALS OF PIC

**SECTION 11: SIGNATURE AND AFFIRMATION**

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

As the Pharmacist in Charge I acknowledge and certify by my signature that I have read, understand, and will abide by 32 MRS Chapter 117 of the Maine Pharmacy Act and the related Laws and Rules. I also acknowledge my duties and responsibilities to the management and operation of the pharmacy named in this application in all matters directly or indirectly related the practice of pharmacy, including but not limited to, any matters related to health, welfare, and the safety of the public.

By submitting this completed form, I understand that the Maine Board of Pharmacy will rely upon this information as being truthful and factual and that sanctions may be imposed, including denial, suspension or revocation of the pharmacy license and/or my pharmacist license, if this information is found to be false.

Pharmacist in Charge Name (print legibly)	License number
Signature of Licensed Pharmacist in Charge	Date