



# STATE OF MAINE BOARD OF PHARMACY

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

### Rural Health Center

#### 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. You will be required to submit a new application together with the fee, fees are nonrefundable, including applications that are incomplete. 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)

## **INFORMATIONAL**

- ✓ Receipt of your application does not constitute entitlement to begin to do business in 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 do business in 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](http://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.

## **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](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 and 7
- Board Rules, Chapter 9

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.



**SECTION 1: TYPE OF APPLICATION**

- Initial Application
- Change of Ownership
- Change of Location
- Change of Consultant Pharmacist

Date of change \_\_\_\_\_

Previous License Number: \_\_\_\_\_  
(this license will be terminated upon issuance of new license)

**Important, please read:** Refer to 32 MRSA §13752, Sec. 3. Please note that a license is not transferrable to another owner or a new location and is subject to a new application and licensure before you begin to operate under new ownership or in a new location.

**SECTION 2: CENTER TO BE LICENSED (Ref. 32 MRS, Section 13762).**

**This Rural Health Center is which of the following:**

- It serves a rural area without a pharmacy;
- It is located in a community where available pharmacy services can not meet the documented need; or
- It requires a license in order to receive pharmaceutical discounts authorized by the federal Veterans' Health Care Act of 1992, Title VI.

**SECTION 3: CONTACT INFORMATION (person responsible for completing and submission of application must be an owner or officer of the entity).**

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

**SECTION 4: COMPANY INFORMATION**

Name of Rural Health Center	
Rural Health Center Telephone Number	Rural Health Center Fax Number
(    )	(    )
E-mail Address	
Web Address	
All Trade Names or Business Names of the Rural Health Center	

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INITIALS OF APPLICANT

**SECTION 5: OWNERSHIP**

<b>Private Nonprofit Corporation:</b> Please include an organizational chart. (Please type or print legibly) <i>Please see Board Rules, Chapter 9, Sec. 1(1)</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		
(      )			

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INITIALS OF APPLICANT

**SECTION 6: 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 7: PHARMACY PROVIDER** (Ref. 32 MRS 13761(1))

Name of Pharmacy Provider		Pharmacy License Number	
Address of Pharmacy Provider			
City		State and Zip Code	
Phone Number of Pharmacy Provider			
(     )			

**SECTION 8: CONSULTING PHARMACIST** (Please see Board Rules, Chapter 14, Sec 1)

Consulting Pharmacist			
Pharmacist License Number		Expiration Date	
Contact Address	City	State	Zip Code
E-mail Address			

**SECTION 9: CONTRACT** (Ref. Board Rules Chapter 9, Sec. 1(2) and Chapter 14, Section 1)

A copy of the contract between the rural health center and consulting pharmacist is enclosed

**SECTION 10: HOURS OF OPERATION OF RURAL HEALTH CENTER** note a.m./p.m.

Day	Open	Close
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

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INITIALS OF APPLICANT

**SECTION 11: THIS SECTION TO BE COMPLETED BY THE Rural Health Center 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"><li>1. Provide a <u>detailed explanation</u> in the offender's own words on a separate sheet of paper.</li><li>2. Attach a copy of the <u>Court Judgment and Decision</u>.</li><li>3. If a motor vehicle criminal offense, attach a copy of a recent motor vehicle report.</li></ol>	<p><input type="checkbox"/> Yes</p> <p><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"><li>1. List the jurisdiction(s) that denied your license or issued discipline and date of action: State/Jurisdiction _____ Date _____ State/Jurisdiction _____ Date _____</li><li>2. Submit a copy of the consent agreement or decision and order for each of the above.</li><li>3. Provide a detailed explanation in your own words on a separate sheet of paper.</li></ol>	<p><input type="checkbox"/> Yes</p> <p><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"><li>1. DEA action <u>OR</u> 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>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>

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INITIALS OF APPLICANT

**SECTION 12: CONSULTING PHARMACIST INFORMATION (Must be completed by Consulting Pharmacist)**

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 Consulting Pharmacist, 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 Consulting Pharmacist, 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 Consulting Pharmacist, 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 Consulting Pharmacist, 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

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

## **SECTION 13: FLOOR PLAN**

### **A. Floor Plan of Rural Health Center**

Scaled drawing and floor plan of the pharmacy which details the usage of each area. Please limit the copy of the floor plan to an 8"x11" or 8"x14" paper size if possible. (See Board Rules, Chapter 9, Section 1(4))

#### ***Alert for future alteration of the prescription filling area.***

Pursuant to Board Rules, Chapter 9, Section 5, a rural health center may not alter the physical dimension of the prescription filling area or add or change the doors, windows or other means of access to the prescription filling area prior to receiving approval from the board. The pharmacy shall provide a scaled drawing of the proposed alteration at the time it requests approval.

## **SECTION 14: STORAGE AND SECURITY**

Pursuant to Board Rules, Chapter 14, Section 4, "a rural health center shall ensure the security of drugs at all times. A rural health center shall keep drugs in a locked storage area during non-business hours. A rural health center that provides pharmacy services must be protected by an alarm system."

- Submit documentation to demonstrate compliance with the storage and security requirements; or
- For good cause shown, the board may waive the storage and security requirements. Please submit your request in writing for consideration.

## **SECTION 15: 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.

INITIALS OF APPLICANT

**Rural Health Center—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.
- Scaled drawing and floor plan.
- Demonstration of storage and security compliance.
- Waiver request, if applicable.
- Company’s organizational chart.
- 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.
- 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.

**SECTION 16: 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 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