GEORGIA BOARD OF PHARMACY

2 Peachtree Street, N.W., 6th Floor
Atlanta, GA 30303
(404) 651-8000

Please read the instructions carefully and be familiar with the laws and rules governing the practice of Pharmacy in the State of Georgia. Visit our website for information: **www.gbp.georgia.gov**

INFORMATION SHEET FOR FILING AN APPLICATION FOR A PHARMACY LICENSE

- The **required non-refundable application fee** must accompany the completed application. The fee for checks returned due to non-sufficient funds is $30.00.

- **SUBMIT APPLICATION IN A 9X12 or LARGER ENVELOPE –** Do not staple pages or check/money order. Do not fold pages of the application.

- The Board of Pharmacy requires an inspection of any pharmacy facility **located within the State of Georgia** prior to the issuance of a license. The request for the **inspection** should be made with the **Georgia Drugs and Narcotics Agency (GDNA)** by the applicant after submitting the completed application to the Board office. You may contact GDNA at (404) 656-5100 or **(**800) 656-6568. Do ***not*** contact GDNA for an inspection until you are notified by the Board that your application has been processed; GDNA will not inspect or set up an inspection without a processed application.

- **Allow a minimum of 25 business days for the processing of the application**.

- The Board staff cannot provide legal advice, interpretations of the laws and rules, and cannot advise you as to which type of license your business should apply for; you will need to seek private legal counsel to assist you regarding these matters.

- Please refer to Georgia law and Board rules regarding the requirements for the license type for which are applying. These may be found on the Board's website at: www.gbp.georgia.gov.

- **Georgia issues permits for non-resident retail pharmacies, but applicants may only apply for permits using the non-resident pharmacy permit application.**

- **For Researcher Applicants - registration for those who plan to obtain, possess, or conduct research, teaching, analysis or drug dog detection/training with controlled substances:** The primary individual in charge/responsible for the protocol for the program MUST provide with the application evidence of US citizenship (copy of birth certificate or passport) or qualified alien status under the Work Opportunity and Personal Responsibility Act of 1996.

- **For Wholesalers and Reverse Distributors Applicants:** Wholesalers or Reverse Distributors within the State of Georgia are required, by law to be licensed with the Georgia State Board of Pharmacy. Wholesalers or Reverse Distributors located outside the State of Georgia, but wholesale, distribute, or supply drugs to individuals or facilities within the State of Georgia, are also required by law to be licensed with the Georgia State Board of Pharmacy.

- A GDNA inspection is **not** required for out-of-state facilities (i.e., wholesalers). However, you will still need to contact GDNA at 404-656-5100 to further the process of your application. GDNA will process the personal certification forms that wholesalers and reverse distributors submit with their applications.

- **Oxygen** wholesalers who provide products **directly** to the patient/end user **are not required to be licensed in Georgia.**

- **Wholesalers**: Monthly transaction reports involving controlled substances are required by law to be maintained and in your possession. GDNA may request copies of these records at any time**.**

- **Which pages of the application do I submit?**

  Retail, Hospital, Retail/Home Health, and Retail PBM applicants submit pages **3, 4, 15, 16** and **17**.
  Nuclear Pharmacy applicants submit pages **3, 5, 15, 16** and **17**.
  Researcher Applicants submit pages **3, 6, 7, 15, 16** and **17**. Also, attach a brief resume and current photo (2x2 passport style photo).
  Opioid Treatment Clinic and Outpatient Clinic applicants submit pages **3, 8, 15, 16** and **17**.
  Prison Pharmacy applicants submit pages **3, 9, 15, 16** and **17**.
  Manufacturer applicants submit pages **3, 10, 13, 15, 16, 17, 18** and **19**
  Wholesaler and Reverse Distributor applicants submit pages **3, 11, 12, 13, 15, 16, 17, 18** and **19**.
  Remote Automated Medication System (RAMS) applicants submit pages **3, 14, 15, 16** and **17**.

- **All applications require completed affidavit of applicant and appropriate secure and verifiable documents.**

- **Please note: If more than one change is made to a license, a new license number will be issued.**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Do Not Write In This Section:
Receipt#: _____
Amount: _____
Applicant #: _____
Initials/Date: _____

GEORGIA BOARD OF PHARMACY

Address: **2 Peachtree Street, N.W., 6th Floor, Atlanta, GA 30303**
Telephone #: **(404) 651-8000**
Fax #: **(678) 717-6694**
Website: **www.gbp.georgia.gov**

APPLICATIONS ARE VALID FOR ONE YEAR

The fee for a name change is only $100.00. The fee for checks returned due to non-sufficient funds is $30.00.

Purpose of Application:
License Type / Application Fee:

( ) Retail Pharmacy-$500.00 – (Georgia only)
( ) Hospital Pharmacy - $500.00 (Georgia only)
( ) Retail/Home Health - $500.00 (Georgia only)
( ) Retail/PBM - $500.00
( ) Researcher Pharmacy - $100.00
( ) Opioid Treatment Clinic - $500.00 (Georgia only)
( ) Outpatient Clinic - $500.00
( ) Prison Pharmacy - $500.00 (Georgia only)
( ) Wholesaler - $1000.00
( ) Reverse Distributor - $1000.00
( ) Manufacturer Pharmacy - $1000.00
( ) Nuclear Pharmacy - $500.00
( ) Remote Automated Medication System (RAMS) - $500.00

Purpose of Application:

( ) New Registration
( ) Reinstatement - $350 + late renewal fee for each renewal period missed
( ) Change of Ownership
( ) Change in Location
( ) Change in Schedule
( ) Change in Primary Person in Charge (Researcher's only) - $100.00
Name: _____
( ) Change in Facility Name - $100.00
Previous name: _____

Current License Number: _____

Location of Facility:
( ) **IN** Georgia ( ) **OUTSIDE** Georgia

Affiliation:
Name or title under which business is conducted: _____
(Please list legal name and d.b.a. name

Physical Address _____
(P.O. Box not acceptable) Number and Street City/State Zip County

Mailing Address _____
(If different) Number and Street City/State Zip

_____ **Employer Identification Number:** _____
Telephone Number (Day)

Person to be contacted for communication, or notice and citation matters:

Name: _____ Title: _____

Address: _____

Phone #: (____)_____-_____ Email Address: _____

Acknowledgement of your application will be sent by email. Also, if further information is needed, email is the most efficient way for Board staff to contact you so that your application can be processed in the most efficient manner. Your email address will not be shared with any third party. The contact person listed above is the only person that Board staff is authorized to speak with in regards to this application.

RETAIL, HOSPITAL, RETAIL/HOME HEALTH, AND RETAIL PBM APPICANTS COMPLETE THIS PAGE

1. Type of Ownership: ( ) Individual ( ) Partnership ( ) Corporation ( ) Government

Name of Pharmacist-in-Charge: _____ License No. _____

2. Owner's Name _____
(If a partnership, list names of **all** partners; if a corporation, list names and titles of all corporate officers. Use additional paper if additional space is needed).

3. Names of other registered pharmacists regularly and actively employed in the pharmacy or drug store (attach additional sheets, if necessary):

_____ _____
(Name) (License #) (Name) (License #)

4. Do you have a Class A Balance and other equipment as required in Board Rule 480-10-.12?
( ) Yes ( ) No - *PBM's are exempt.*

5. Does the store keep an exempt narcotics register? **( ) Yes ( ) No - *PBM's are exempt.***

6. Are narcotics stored or locked in a secure place? **( ) Yes ( ) No -** Mixed with stock? **( ) Yes ( ) No - *PBM's are exempt.***

7. Does the store keep a poison register? **( ) Yes ( ) No - *PBM's are exempt.***

8. Date the pharmacy will be open for business: _____

9. Have any of the owners, partners of the firm, or officers of the corporation ever been convicted of any crime under the laws of the United States, Georgia, or any other state pertaining to the manufacturing, distribution, sale or dispensing of drugs or narcotics? **( ) Yes ( ) No (If yes, please attach an explanation and have certified documents sent to the Board office.)**

10. Do you have safeguards to prevent the sale or other distribution of dangerous drugs, prescription drugs, or narcotics to any person other than: Practitioners of the healing arts, registered drug wholesalers, distributors or suppliers, licensed pharmacists, licensed pharmacies, or carriers/warehousemen (for the purpose of carriage or storage)? **( ) Yes ( ) No**

11. Type of drugs you distribute or wish to distribute: ( ) Dangerous Drugs (Legend Drugs) ( ) Controlled Substances

12. Do you understand that every drug wholesaler or reverse distributor registered with the Georgia State Board of Pharmacy is required to submit reports of excessive purchases of controlled substances with the Federal Drug Enforcement Administration and shall be required to submit a copy of each report to the Georgia Drugs and Narcotics Agency? **( ) Yes ( ) No Please Note:** The report requirements do not apply to any wholesalers, manufacturers, or reverse distributors who only ship controlled substances directly to a licensed wholesaler within the State of Georgia.

13. Will this pharmacy use sterile preparations in compounding prescriptions? **( ) Yes ( ) No**

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed during the period any permit issued may be in force and effect.

Firm Name: _____
Applicant Signature: _____
By: _____
(State whether individual Owner, Partner or officer of the corporation)

_____
Date/Seal

NUCLEAR PHARMACY APPLICANTS COMPLETE THIS PAGE

1. Name/License Number of Nuclear Pharmacist in Charge: _____

2. Name/license numbers of other pharmacists and nuclear pharmacists to be employed in the pharmacy:

Pharmacists:		Nuclear Pharmacists:	
_____		_____	
(Name)	(License #)	(Name)	(License #)
_____		_____	
(Name)	(License #)	(Name)	(License #)

3. Do you have the equipment as required under Rule 480-25-.08? **( ) Yes ( ) No**

4. Has an application for radioactive materials license been submitted to the Georgia Department of Natural Resources? **( ) Yes ( ) No** Date submitted: _____

5. Please furnish the information requested in subsections (A), (B), (C), (D), and (E) for each individual owner, all members of the partnership, and all officers and directors of a corporation having less than twenty-six (26) stockholders. In addition, this information must be furnished for:
   - All Stockholders if applicant is a corporation with five (5) or fewer stockholders;
   - One-half (1/2) the stockholders, if the applicant is a corporation with between six (6) and twenty-six (26) stockholders;
   - Corporations having more than twenty-six (26) stockholders need only submit the requested information for the individuals owning more than twenty-five percent (25%) or more of the total stock.

(A) Name/Title: _____

(B) Have you ever been arrested, convicted, sentenced, pled guilty to, pled *nolo contendere* to, or given first offender status for the commission of a felony, misdemeanor, or any offense other than a minor traffic violation? (DWI & DUI's are **not** minor traffic violations.) **( ) Yes ( ) No (If yes, please attach an explanation and have the certified documents sent to the Board office.)**

(C) Have you ever had any restrictions as a Medicaid or Medicare Provider? **( ) Yes ( ) No (If yes, please attach an explanation and have the certified documents sent to the Board office.)**

(D) Have you ever had revoked or suspended or otherwise sanctioned any license issued by any Board or agency in Georgia or in any other State? **( ) Yes ( ) No (If yes, please attach an explanation.)**

(E) Have you ever been denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license by any Board or agency in Georgia or any other State? **( ) Yes ( ) No (If yes, please attach an explanation**.)

The undersigned hereby swears, or affirms, that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon, will be faithfully observed during the period any permit issued may be in force and effect.

Firm Name: _____
Applicant Signature: _____
By: _____
(State whether individual Owner, Partner or officer of the corporation)

_____
Date/Seal

RESEARCHER APPLICANTS COMPLETE THIS PAGE

(Registration for those who plan to obtain, possess, or conduct research, teaching, analysis or drug dog detection/training with controlled substances)

Name of primary individual in charge/responsible for protocol: _____

License Number (if applicable): _____

1. List the drugs (generic names) and the controlled substance schedule numbers that will be used:

_____

_____

2. List the approximate amount of drugs to be used per year: _____

3. Provide a brief description of the protocol for this program:

_____

_____

_____

4. From where will the controlled substances utilized in this program be obtained?: _____

_____

5. Brief description of the security procedures to be used to secure controlled substances used in this program:

_____

_____

_____

_____

RESEARCHER APPLICANTS COMPLETE THIS PAGE

(Registration for those who plan to obtain, possess, or conduct research, teaching, analysis or drug dog detection/training with controlled substances)

PERSONAL DATA SHEET

All persons in charge/responsible for the protocol of the program must complete this form. Attach a brief resume of scientific education and/or training and or/or degrees. Include present and former employers within the past ten years, giving address of each and date of employment. (If law enforcement agency, submit copies of training certificates pertaining to drug dog handling.) Also attach evidence of US citizenship or eligible alien status under the Work Opportunity and Person Responsibility Act of 1996.

1. _____ Title_____
(Last) (First) (Middle)

2. _____
(Address) (City) (State) (Zip)

3. _____ _____
(Date of Birth) (Social Security Number*)

***This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. §19-11-1 and O.C.G.A. §20-3-295, 42 U.S.C.A. §551 and 20 U.S.C.A. §1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.**

4. Have you ever been arrested, convicted, sentenced, pled guilty to, pled *nolo contendere* to, or given first offender status for the commission of a felony, misdemeanor, or any offense other than a minor traffic violation? (DWI & DUI's are **not** minor traffic violations.) **( ) Yes ( ) No (If yes, please attach an explanation and have certified documents sent to the Board office**.)

5. Have you ever had a research permit issued by any State, Federal, or local government revoked, suspended, or otherwise sanctioned? **( ) Yes ( ) No (If yes, provide certified copies of the official documents pertaining to this matter.)**

6. **Please initial the following statement indicating your acknowledgement:**

I am aware that the above information is in connection with application to obtain, possess, or conduct research with controlled substances and the furnishing of false or misleading information in such matters is a felony under Georgia Law. I hereby authorize the Georgia State Board of Pharmacy to receive any criminal history information pertaining to me which may be in the files of any local, State, or Federal criminal justice agency. _____(Initials)

AFFIDAVIT

I swear that all statements made on the application for registration and personal data sheet are true and correct and that all provisions of the law and regulations pertaining to this registration will be faithfully observed during the period of time any license may be in force and effect.

(Signature) (Date)

Sworn to and subscribed before me this
_____ day of_____, _____.

(**ATTACH CURRENT PHOTO HERE)**

_____
Notary Public / Expiration Date/Seal

OPIOID TREATMENT CLINIC AND OUTPATIENT CLINIC APPLICANTS COMPLETE THIS PAGE

Type of Ownership: ( ) Individual ( ) Partnership ( ) Corporation ( ) Government

Please furnish the information requested in subsections (A), (B), (C), (D), and (E) below for each individual owner, all members of a partnership, and all officers and directors of a corporation having less than 26 stockholders.

Name/License Number of Pharmacist in Charge: _____

In addition, this information must be furnished for:

- All stockholders if applicant is a corporation with five (5) or fewer stockholders;
- ½ of the stockholder, if applicant is a corporation with between 6 and 26 stockholders;
- Corporations having more than 26 stockholders need only submit the requested information for individuals owning 25% or more of the total stock.

(A) Name _____
(Indicate whether individual owner, partner, officer, director, and percentage of stock owned.)

Home Address _____
(Address) (City) (State) (Zip)

(B) Have you ever been arrested, convicted, sentenced, pled guilty to, pled *nolo contendere* to, or given first offender status for the commission of a felony, misdemeanor, or any offense other than a minor traffic violation? (DWI & DUI's are **not** minor traffic violations.) **( ) Yes ( ) No (If yes, please attach an explanation and have the certified documents sent to the Board office.)**

(C) Have you ever had any restrictions as a Medicaid or Medicare provider? **( ) Yes ( ) No ( ) (If yes, please attach an explanation.)**

(D) Have you ever had revoked or suspended or otherwise sanctioned any license issued by any Board or agency in Georgia or in any other State? **( ) Yes ( ) No (If yes, please attach an explanation.)**

(E) Have you ever been denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license by any Board or agency in Georgia or any other State? **( ) Yes ( ) No (If yes, please attach an explanation**.)

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed during the period any permit issued may be in force and effect.

Firm Name: _____
Applicant Signature: _____
By: _____
(State whether individual Owner, Partner or officer of the corporation)

Sworn and subscribed before me, this
_____ day of_____, _____

_____
Notary Public / Expiration Date/Seal

PRISON PHARMACY APPLICANTS COMPLETE THIS PAGE

Name of Director of Pharmacy: _____ License #: _____

1. Names of other registered pharmacists regularly and actively employed in the pharmacy:

_____ _____
(Name) (License #) (Name) (License #)

2. List hours of operation: _____

3. Do you have written policies and procedures for the absence of a pharmacist as required in Board Rule 480-8-.04? **( ) Yes ( ) No**

4. Do you have the minimum equipment as required by Board Rule 480-8-.05 entitled "Physical Requirements"? **( ) Yes ( ) No**

5. Is there controlled drug storage for Schedule II drugs? **( ) Yes ( ) No**

6. Date pharmacy will be open for business: _____

7. Has the Director of Pharmacy or any of the pharmacists ever been arrested, convicted, sentenced, pled guilty to, pled *nolo contendere* to or given first offender status for the commission of a felony, misdemeanor or any offense other than a minor traffic violation? (DWI &DUI's are NOT minor traffic violations.) **( ) Yes ( ) No (If yes, please attach an explanation and have certified documents sent to the Board office.)**

8. Has the Director of Pharmacy or any of the pharmacists ever had any restrictions as a Medicaid or Medicare provider? **( ) Yes ( ) No (If yes, please attach an explanation.)**

9. Has the Director of Pharmacy or any of the pharmacists ever had revoked or suspended or otherwise sanctioned any license issued by any Board or Agency in Georgia or in any State? **( ) Yes ( ) No (If yes, please attach an explanation and have certified documents sent to the Board office.)**

10. Has the Director of Pharmacy or any of the pharmacists ever been denied licensure of or, pursuant to disciplinary proceedings, refused renewal of a license by any Board or Agency in Georgia or any other State? **( ) Yes ( ) No (If yes, please attach an explanation.)**

11. Will this pharmacy do sterile compounding? **( ) Yes ( ) No**

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed during the period any permit issued may be in force and effect.

_____ _____
(Printed Name of Warden) (Signature of Warden)

(Signature of Director of Pharmacy)

Sworn and subscribed before me, this
_____ day of_____, _____.

_____
Notary Public / Expiration Date/Seal

MANUFACTURER PHARMACY APPLICANTS COMPLETE THIS PAGE

1. Type of Ownership: ( ) Individual ( ) Partnership ( ) Corporation State of Incorporation (if applicable): _____

2. Names of Owners: If additional space is needed, use additional paper.

_____ (President's Name)	_____ (Address)
_____ (Vice President's Name)	_____ (Address)
_____ (Secretary/Treasurer Name)	_____ (Address)

Previous trade, corporate, or partnership names (if any) and addresses: _____

_____

3. Have you ever had revoked or suspended or otherwise sanctioned any license issued by any Board or Agency in Georgia or in any other State? **( ) Yes ( ) No (If yes, please attach an explanation and certified copies of all documents and records.)**

4. Have you ever been denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license by any Board or Agency in Georgia or any other State? **( ) Yes ( ) No (If yes, please attach an explanation and certified copies of all documents and records.)**

5. List dentifrices manufacture: _____

6. List classes of drugs and medicines manufactured: _____
(Pills, Tablets, Ointments, etc.)

Scientific and Technical personnel:

(A) Names of registered pharmacist employees: _____

(B) Names of chemist employees: _____

(C) State details of the scientific and technical training of individuals listed above, name colleges attended and degrees held by those supervising the manufacturing covered by this application: _____

_____

Give the name, address, and title of the person to whom communication from the Board may be directed and upon whom notices and citations may be served.

Name: _____ Phone Number: _____

_____
Street Address City State Zip

The undersigned hereby swears, or affirms, that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon, will be faithfully observed during the period any permit issued may be in force and effect.

Firm Name: _____

Sworn and subscribed before me, this _____ day of _____,_____.

Applicant Signature: _____

By: _____
(State whether individual Owner, Partner or officer of the corporation)

_____
Notary Public / Expiration Date/Seal

WHOLESALER AND REVERSE DISTRIBUTOR APPLICANTS COMPLETE THIS PAGE

1. Type of Ownership: ( ) Individual ( ) Partnership ( ) Corporation

2. State of Incorporation _____
(If Applicable)

3. Names of Owners: If additional space is needed, use additional paper.

_____	_____
(President's Name)	(Address)
_____	_____
(Vice President's Name)	(Address)
_____	_____
(Secretary/Treasurer's Name)	(Address)

4. List the state(s) in which the facility(s) is located that will be supplying drugs to Georgia:

_____

5. Which of the above-mentioned state(s) require licensure of Wholesalers or Reverse Distributors?

_____
(The enclosed certification of licensure form **MUST BE** completed by each of the above state(s) and submitted with this application.)

6. Have you ever had a revoked, suspended, or otherwise sanctioned license issued by any board or agency in Georgia or any other state? **( ) Yes ( ) No (If yes, please attach an explanation and certified copies of all documents and records.)**

7. Have you ever been denied issuance of, or pursuant to disciplinary proceedings, refused renewal of a license by any board or agency in Georgia or any other state? **( ) Yes ( ) No (If yes, please attach an explanation and certified copies of all documents and records.)**

8. Have any of the owners, partners of the firm, or officers of the corporation ever been convicted of any crime under the laws of the United States, Georgia, or any other state pertaining to the manufacturing, distribution, sale or dispensing of drugs or narcotics? **( ) Yes ( ) No (If yes, please attach an explanation and certified copies of all documents and records.)**

9. Person to be contacted for communication, or notice and citation matters:

Name: _____ Title: _____

Address: _____

Phone #: (____) _____-_____

10. Do you have safeguards to prevent the sale or other distribution of dangerous drugs, prescription drugs, or narcotics to any person other than: Practitioners of the healing arts, registered drug wholesalers, distributors or suppliers, licensed pharmacists, licensed pharmacies, or carriers/warehousemen (for the purpose of carriage or storage)?
( ) Yes ( ) No

WHOLESALER AND REVERSE DISTRIBUTOR APPLICANTS COMPLETE THIS PAGE

11. Type of drugs you distribute or wish to distribute: ( ) Dangerous Drugs (Legend Drugs) ( ) Controlled Substances

12. Do you understand that every drug wholesaler or reverse distributor registered with the Georgia State Board of Pharmacy is required to submit reports of excessive purchases of controlled substances with the Federal Drug Enforcement Administration and shall be required to submit a copy of each report to the Georgia Drugs and Narcotics Agency? **( ) Yes ( ) No**

Please Note: The report requirements for question #12 do not apply to any wholesalers, manufacturers, or reverse distributors who only ship controlled substances directly to a licensed wholesaler within the State of Georgia.

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed during the period any permit issued may be in force and effect.

Firm Name: _____

Applicant Signature: _____

By: _____

(State whether individual Owner, Partner or officer of the corporation)

Sworn and subscribed before me, this
_____ day of _____,_____.

_____

Notary Public / Expiration Date/Seal

MANUFACTURER, WHOLESALER, and REVERSE DISTRIBUTOR APPLICANTS COMPLETE THIS PAGE

CERTIFICATION OF LICENSURE AS A
MANUFACTURER, WHOLESALER, OR REVERSE DISTRIBUTOR

This certification form must be completed by the State Licensing Board for each state in which a license is held and returned to the applicant to submit with the Georgia State Board of Pharmacy licensing application.

This is to certify that _____ was issued

license number _____ on ___/_____/_____ to operate as a (circle one) manufacturer,

wholesaler, or reverse distributor in the State of _____.

This is to further certify that the above-named manufacturer, wholesaler, distributor, or supplier's license is current and in good standing and that there have never been any sanctions against the holder's license.

This, _____day of_____,_____.

_____ _____
(Print Name) (Signature)

_____
(Title)

_____
(Complete Name of Board)

REMOTE AUTOMATED MEDICATION SYSTEM (RAMS) APPLICANTS COMPLETE THIS PAGE

Name of Pharmacy making application for this RAMS: _____

Pharmacy License Number: _____

Name of Pharmacist-in-Charge: _____ License #: _____

Pharmacy Owner's Name _____
(If a partnership, list names of **all** partners; if a corporation, list names and titles of all corporate officers. Use additional paper if additional space is needed).

(1) Has any owner of this pharmacy ever been arrested, convicted, sentenced, pled guilty to, pled *nolo contendere* to, or given first offender status for the commission of a felony, misdemeanor, or any offense other than a minor traffic violation? (DWI & DUI's are **not** minor traffic violations.) **( ) Yes ( ) No (If yes, please attach an explanation and have the certified documents sent to the Board office.)**

(2) Has this pharmacy ever had any restrictions as a Medicaid or Medicare Provider? **( ) Yes ( ) No (If yes, please attach an explanation and have the certified documents sent to the Board office.)**

(3) Has this pharmacy ever had revoked or suspended or otherwise sanctioned any license issued by any Board or agency in Georgia or in any other State? **( ) Yes ( ) No (If yes, please attach an explanation.)**

(4) Has this pharmacy ever been denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license by any Board or agency in Georgia or any other State? **( ) Yes ( ) No (If yes, please attach an explanation**.)

(5) Does this pharmacy have a policy and procedure manual at the skilled nursing facility or hospice that includes all of the requirements for Board Rule 480-37-.03(a)? **( ) Yes ( ) No**

(6) Does the applicant agree to comply with all laws and rules for the Georgia State Board of Pharmacy, including all of the rules for RAMS included in Rule 480-37? **( ) Yes ( ) No**

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed during the period any permit issued may be in force and effect.

Firm Name: _____

Sworn and subscribed before me, this

Applicant Signature: _____

_____ day of _____, _____.

By: _____
(State whether individual Owner, Partner or officer of the corporation)

Notary Public / Expiration Date/Seal

AFFIDAVIT OF APPLICANT

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia State Board of Pharmacy and I agree to abide by these laws and rules, as amended from time to time.

By signing this application, electronically or otherwise, I hereby swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. § 50-36-1:

1) _____ I am a United States citizen 18 years of age or older. Please submit a copy of your current Secure and Verifiable Document(s) such as driver's license, passport, or document as indicated on pages 16 & 17 of this application.

2) _____ I am not a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by the Department of Homeland Security or other federal immigration agency. Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and, if needed, SEVIS number.

In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia State Board of Pharmacy and/or criminal prosecution.

_____ _____

Signature of Applicant Date

_____

Print Applicant's Name

Personally appeared before me, the undersigned official authorized to administer oaths, comes

_____ who deposes and swears that he/she is the person who executed this
(Applicant's Name)

application for a pharmacy license, permit, or registration in the State of Georgia; and that all of the statements herein contained are true to the best of his/her knowledge and belief.

Sworn to and subscribed before me this _____ day of _____, _____.

Notary Public Signature _____ _____

County State

My Commission Expires: _____

(seal)

APPLICANT: PLEASE CHECK THE FORM OF IDENTIFICATION BELOW THAT YOU POSSESS. RETURN THIS FORM ALONG WITH A COPY OF YOUR APPROPRIATE DOCUMENTATION

_____

Name

Secure and Verifiable Documents under O.C.G.A. § 50-36-2
Issued August 1, 2012 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

_____ A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

_____A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. §50-36-2(b)(3); 22 CFR § 41.2]

_____A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

_____A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____A Certification of Report of Birth issued by the United States Department of State (Form DS-1350 [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____A Certification of Birth Abroad issued by the United States Department of State (Form FS-545) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____A Consular Report of Birth Abroad issued by the United States Department of State (Form FS-240) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____An original or certified copy of a birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

_____In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § secure and 50-36-2(c)]

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PERSONNEL CERTIFICATION FORM

For All persons applying for a Georgia State Board of Pharmacy Manufacturer, Wholesale or Reverse Distributor Pharmacy Facility

Instructions: ***PLEASE RETURN ORIGINAL FORM TO ADDRESS LISTED ABOVE (Only Pages 18 & 19)***

Completion of this form is a necessary part of the applicant background investigation to be conducted by the Georgia Drugs and Narcotics Agency (GDNA) as part of the licensing approval process.

This form should be completed by each person named in the application as an owner of the firm, including the President/CEO, Vice President, and Secretary/Treasurer, and the individual who is the company's contact person for the Board and GDNA. For larger corporations with multiple divisions and officers, please limit the contact personnel to 5 individuals, including the President/CEO, Vice Presidents and/or others directly responsible for drug acquisition and distribution, and the responsible person for contact with the Board and GDNA.

When an application is filed for a change of ownership, each new officer (or responsible officer) must complete the form.

All information requested on this form is mandatory. Failure to provide any and all of the requested information will result in an incomplete background investigation and rejection of the application. This information will be used to determine your qualifications for registration and licensure under the Georgia Pharmacy Law. This information may be shared with other government agencies upon receipt of an official request.

Applicant Name: _____ **Sex:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Social Security #:** _____

Contact Telephone: _____ **Contact Fax:** _____

Firm Name: _____

Position with the Firm: _____

On the following questions, please check the appropriate Yes or No box for each of the following questions:(If the answer is Yes to Question 2, 3, or 4, you must attach a written explanation providing complete information to explain each Yes answer.)

Failure to provide an explanation will delay the application process

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1) Licensure – (Must include present and previous, work and ownership history for at least 20 years)

	YES	NO
a) Do you currently own, have owned in the past, work or worked for, any type of licensed/permitted pharmacy, drug wholesaler, manufacturer or reverse distributor?	_____	_____

If Yes to a), please list the name of the firm, complete address, and date(s) of ownership and/or employment. (attach sheet(s) if necessary)

_____

_____

_____

b) Are you currently, or have ever been, licensed as a pharmacist?	_____	_____

If Yes to b) please list the state(s) where licensed and the license number(s).

_____

_____

2) Have you ever had, or been associated with, a personal or firm's professional license that has been denied, suspended, revoked, or sanctioned taken by this or any other state or federal governmental authority?	_____	_____
3) Have you ever been arrested for, convicted of, or pled *NoLo* to any violation of any law of a foreign country, the United States, or any state law, including those set aside under The First Offender's Act? Please do not include minor traffic offenses.	_____	_____
4) Have you ever owned or been associated with any firm which has been indicted, convicted of, or pled *NoLo* to any violation of any law of a foreign country, the United States, or any state law, including those set aside under The First Offender's Act?	_____	_____

5) What are your responsibilities with this firm – present and past?

_____

_____

_____

I certify under penalty of perjury of the applicable laws of the United States and the State of Georgia to the truth and accuracy of all of the foregoing information. If false, inaccurate, or misleading information is provided on this document, the Georgia State Board of Pharmacy (Board) may refuse to issue or renew any facility license associated with the affiant, or the Board may suspend, revoke, fine, or sanction the facility license associated with the affiant, and/or the Georgia license of the affiant, if applicable, pursuant to the procedures set forth in Georgia laws or rules. And further, I hereby authorize the Georgia Drugs and Narcotics Agency to receive any Criminal History Information and Driver History Information pertaining to me which may be in the files of any local, state, or federal criminal justice agency.

Signature: _____ Date: _____

Sworn to and subscribed before me this
____ day of _____,_____

_____ My Commission Expires: _____

Notary Public

NOTARY SIGNATURE & SEAL REQUIRED