

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

NOTICE OF INTENT TO SERVE AS AN AUTHORIZED COLLECTOR

- The **notice processing fee** must accompany the completed form. The fee for checks returned due to non-sufficient funds is \$30.00.
- **SUBMIT NOTICE IN A 9X12 or LARGER ENVELOPE** – Do not staple pages or check/money order. Do not fold pages.
- While the Georgia Board of Pharmacy (“Board”) does not require a facility that intends to serve as an authorized collector to be inspected by the Georgia Drugs and Narcotics Agency (GDNA) within thirty (30) days of filing notice of intent to receive drugs for disposal, GDNA may conduct an inspection of any place, premises, or receptacle utilized by an authorized collector in relation to collection, retention, and disposal of drugs. Do **not** contact GDNA for an inspection unless you are notified by the Board that your notice form has been processed, and you have been selected for an inspection. GDNA will not inspect or set up an inspection without a processed form.
- **Allow a minimum of fifteen (15) business days for the processing of the notice form.**
- The Board staff cannot provide legal advice, interpretations of the laws and rules and cannot advise you; if you require legal advice, you will need to seek private legal counsel to assist you regarding these matters.
- If you have questions regarding authorized collection, please refer to applicable federal law, regulations, and Board rules regarding the requirements for authorized collection. Ga. Comp. R. & Regs. c. 480-50, “Drug Disposal and Authorized Collectors,” may be accessed through the “Laws, Policies, and Rules” section of the Board’s website at: www.gbp.georgia.gov.



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

NOTICE OF INTENT TO SERVE AS AN AUTHORIZED COLLECTOR

The Notice Processing Fee is \$25. The fee for checks returned due to non-sufficient funds is \$30.00.

Type of Facility:

- Retail Pharmacy
- Hospital/Clinic with an On-site Pharmacy
- Long-Term Care Facility
- Manufacturer Pharmacy
- Narcotic Treatment Program
- Reverse Distributor
- Wholesaler

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

Telephone Number (Day) Georgia Pharmacy Permit/License Number

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

Name: _____ Title: _____

Address: _____

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

Acknowledgement of receipt of notice 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 notice 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 notice.

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

2. Names and license numbers of authorized employees who remove and seal inner-liners and maintain records:

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

3. Name, address, and license number of intended reverse distributor:

(Please list legal name and d.b.a. name) (License number)

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

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

4. Number of collection receptacles: _____

5. If the facility is a pharmacy, please check "yes" or "no" to the following questions. If the facility is not a pharmacy, please select "not applicable."

Is the collection receptacle or are the collection receptacles in the immediate vicinity of the prescription department?
 YES NO NOT APPLICABLE

Can the collection receptacle or receptacles be observed from the prescription department areas where controlled substances are stored by registrants and where an authorized employee is present?
 YES NO NOT APPLICABLE

Is there a sign displayed stating that non-controlled and CII-Vs can be accepted and placed in the receptacle?
 YES NO NOT APPLICABLE

6. If the facility is a hospital or clinic, please check "yes" or "no" to the following questions. If the facility is not a hospital or clinic, please select "not applicable."

Is the collection receptacle or are the collection receptacles in an area monitored by employees?
 YES NO NOT APPLICABLE

Is the collection receptacle or are the collection receptacles in an area where emergency or urgent care is provided?
 YES NO NOT APPLICABLE

7. If the facility is an opioid treatment facility, please check "yes" or "no" to the following questions. If the facility is not an opioid treatment facility, please select "not applicable."

Is the collection receptacle or are the collection receptacles located in a room that contains other controlled substances?
 YES NO NOT APPLICABLE

Is there collection receptacle or are the collection receptacles located in a securely locked room with controlled access?
 YES NO NOT APPLICABLE

8. Date on which registered with the DEA to become authorized collector: _____

The undersigned hereby swears or affirms that all statements made herein are true and correct and that all applicable provisions of the law and regulations will be faithfully observed during the period the facility is an authorized collector.

Facility Name: _____

Signature of Authorized Representative: _____

Printed Name and Title of Authorized Representative: _____

Sworn to and subscribed before me on this ____ day of _____, 201__.

Notary Public

My commission expires: _____

**Georgia Drugs and Narcotics Agency
254 Washington Street SW, Suite G2000
Atlanta, GA 30334
404-656-5100 / 800-656-6568 / fax 404-651-8210**

PERSONNEL CERTIFICATION FORM

For all persons listed as “authorized employees” who remove and seal inner-liners and maintain records:

Instructions: ***PLEASE RETURN ORIGINAL FORM (pages 5-6) TO ADDRESS LISTED ABOVE.***

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

This form should be completed by the pharmacist-in-charge, each person named in the notice form as “authorized employees” who remove and seal inner-liners and maintain records, and the responsible person for contact with the Board and GDNA, if not already included as the pharmacist-in-charge or as an authorized employee.

When the pharmacist-in-charge changes or the facility adds a new authorized employee, the new individual must complete this 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 notification. This information shall assist in determining eligibility for authorization as a collector. This information may be shared with other government agencies upon receipt of an official request.

Applicant Name: _____ **Gender:** _____

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 processing of the notification.

PERSONNEL CERTIFICATION FORM – Page 2

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 authorize collection of drugs for disposal by the facility 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, 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 _____, _____

Notary Public My Commission Expires: _____

NOTARY SIGNATURE & SEAL REQUIRED