DIVISION OF MEDICAL QUALITY ASSURANCE
BOARD OF PHARMACY
4052 BALD CYPRESS WAY, BIN #C-04
TALLAHASSEE, FLORIDA 32399-3254
(850) 245-4292

COMMUNITY PHARMACY PERMIT APPLICATION AND INFORMATION

January 2018

Florida HEALTH

Dear Florida Pharmacy Permit Applicant,

Thank you for applying for a pharmacy permit in the State of Florida. The information in this packet has been designed to provide the essential information required to process your application in a timely manner. Your assistance in providing all required information will enable the Florida Board of Pharmacy (the Board) staff to process your application as soon as possible. You are encouraged to apply as early as possible to avoid processing delays caused by large volumes of applicants.

Florida Statutes require a completed application and fees before your application can be reviewed. Please read these instructions carefully and fully before submitting your application. You should keep a copy of the completed application and all other materials sent to the Board office for your records. When you mail the completed application and fees, use the address noted in the instructions and on the application form.

When your application arrives, your fees will be deposited and verified before the staff review can begin. You will receive a letter acknowledging receipt of your application. The staff will notify you within 30 days if any materials are incomplete.

If you need to communicate with the Board staff, you are encouraged to email the Board staff at info@floridaspharmacy.gov, or you may at call us at (850) 245-4292. Phone calls are returned within 24 hours and emails are responded to within 48 hours during normal business hours. Our staff is committed to providing prompt and reliable information to our customers. Many procedures have been streamlined to expedite the processing of applications; we certainly welcome your comments on how our services may be improved.

Sincerely,

The Board of Pharmacy

COMMUNITY PHARMACY PERMIT APPLICATION INFORMATION

Whether opening a new establishment, changing locations, or changing owners, a pharmacy permit is required prior to operating in the State of Florida. The permit application must be completed and returned to the Florida Board of Pharmacy with the required fee of $255.00. The application MUST have the original signatures of the owner or officer of the establishment and the Prescription Department Manager (PDM). If compounding sterile preparations, submit an additional application on Form DH-MQA 1270, "Special Sterile Compounding Permit" and pay the additional permitting fee.

A Community Pharmacy provides outpatient pharmacy services, and is open for a minimum of 20 hours per week unless reduced hours have been approved by the Board. Section 465.018, Florida Statutes, requires a permit holder to designate a pharmacist licensed in the State of Florida as the manager of the prescription department. The Prescription Department Manager (PDM) is responsible for ensuring the pharmacy permittee's compliance with all statutes and rules governing the practice of the profession of pharmacy, including maintenance of all drug records and ensuring the security of the prescription department, and shall competently and diligently exercise their responsibilities as a prescription department manager. Please see Rule 64B16-27.450, F.A.C., for more information.

Section 465.022(4), Florida Statutes, also provides that an application for a pharmacy permit must include the applicant's written policies and procedures for preventing controlled substance dispensing based on fraudulent representations or invalid practitioner-patient relationships. Pursuant to Rule 64B16-28.100(1)(d), F.A.C., the policy and procedure manual for a Community Pharmacy shall contain the procedures implemented to minimize the dispensing of controlled substances based on fraudulent representations as follows:

1. Provisions to identify and guard against invalid practitioner-patient relationships.
2. Provisions to guard against filling fraudulent prescriptions for controlled substances.
3. Provisions to identify prescriptions that are communicated or transmitted legally.
4. Provisions to identify the characteristics of a forged or altered prescription.

Application Processing

Please read all application instructions before completing your application.

1) Please mail the application and the $255.00 application fee (cashier's check or money order made payable to the FLORIDA DEPARTMENT OF HEALTH) to the following address:

Application & Fees:
Department of Health
Board of Pharmacy
P.O. Box 6320
Tallahassee, Florida 32314-6320

Express Mail ONLY
Department of Health
Board of Pharmacy
4052 Bald Cypress Way, Bin C-04
Tallahassee, FL 32399-3254

Within 30 days of receipt of your application and fees, the Board office will notify you of the receipt of your application, any required documents, and your status. If the application is complete, you will be notified that an inspector will contact you to setup an inspection appointment. If your application is incomplete, you will be notified in writing of what is required to make your application complete.

2) Submit fingerprint results.

Failure to submit fingerprints will delay your application. All owners, officers, and PDMs are required to submit a set of fingerprints unless the corporation is exempt under Section 465.022, Florida Statutes, for corporations having more than $100 million of business taxable assets in this state. These corporations are only required to have the PDM to submit fingerprints.

Electronic fingerprint information ("EFI") that has been submitted to the Florida Agency for Health Care Administration may be accessible by the Florida Department of Health for a period of sixty (60) months. If the Department is able to access EFI from AHCA, applicants will not be required to resubmit EFI for additional or new applications submitted during this time period. After sixty (60) months, new electronic fingerprint information must be submitted as part of all applications. **Note: If your officer, owner, or PDM has already been fingerprinted at the time you are completing this Community Pharmacy permit application, please ensure to provide the Transaction Control Number (TCN), if known, with the requested information in the application.**

Applicants may use any Livescan vendor that has been approved by the Florida Department of Law Enforcement to submit their fingerprints to the department. Please ensure that the Originating Agency Identification (ORI) number is provided to the vendor when you submit your fingerprints. If you do not provide an ORI number or if you provide an incorrect ORI number to the vendor, the Board of Pharmacy will not receive your fingerprint results. The applicant is fully responsible for selecting the vendor and ensuring submission of the prints to the Department.

How do I find a Livescan vendor in order to submit my fingerprints to the Department?
The Department of Health accepts electronic fingerprinting service offered by Livescan device vendors that are approved by the Florida Department of Law Enforcement and listed at their site. You can view the vendor options and contact information at:

http://www.floridahealth.gov/licensing-and-regulation/background-screening/livescan-service-providers.html

What information must I provide to the Livescan vendor I choose?

- If you are an applicant seeking a license for any profession regulated by the Department of Health, which requires a criminal background search as a condition of licensure, you must provide accurate demographic information at the time your fingerprints are taken, ***including your Social Security number***. The Department will not be able to process a submission that does not include your Social Security number.
- You must provide the correct ORI number.

Where do I get the ORI number to submit to the vendor?

- The ORI number for the pharmacy profession is **EDOH4680Z.**

Attestation for Business Taxable Assets

- If the applicant has more than $100 million dollars of business taxable assets in this state, please submit a formal opinion letter from a Certified Public Accountant duly

licensed in the state of your principal place of business affirming the corporation has more than $100 million of business taxable assets in this state for the previous tax year. In lieu of submitting a formal opinion letter from a Certified Public Accountant, the applicant may submit a copy of its Florida Corporate Income/Franchise and Emergency Excise Tax Return (Form F-1120, Effective 01/09).

3) Privacy Statement and Attestation

In order for the Board of Pharmacy Office to receive your Livescan electronic fingerprinting results, you must affirm that you have been provided with and read the attached statement from the Florida Department of Law Enforcement regarding the sharing, retention, and right to challenge incorrect criminal history records, and the "Privacy Statement" document from the Federal Bureau of Investigation. The appropriate form(s) to provide this affirmation are included within Items #1 and #2 of the application.

Licensure Process

Once the application is deemed complete, the Board staff authorizes an inspection. Upon completion of the inspection, the inspector notifies the Board office as to whether the inspection was satisfactory or unsatisfactory. If the inspection is satisfactory, a permit number is issued within 7-10 days. You will receive the actual copy of your license within 7 days. **Please wait 7-14 days from your satisfactory inspection before checking on the status of your permit with the Board office**.

You may look up your license number on our website at http://www.flhealthsource.com/ under "Verify a License."

The Board recognizes that a delay may exist between the time a pharmacy receives a Florida pharmacy permit and commences to operate. Accordingly, upon receipt of Community Pharmacy permit, a pharmacy may delay commencement of operations in compliance with the requirements provided in Rule 64B16-28.1081, F.A.C.

Drug Enforcement Administration (DEA)

Please note that the DEA will not issue a registration until the Florida Board of Pharmacy has issued a pharmacy permit. More information is available by visiting the DEA website at http://www.DEAdiversion.usdoj.gov, or by contacting them at (800)667-9752.

IMPORTANT NOTICE: Pursuant to Section 465.022(5), F.S., the Department or Board shall deny an application for a pharmacy permit if the applicant or an affiliated person, partner, officer, director, or prescription department manager or consultant pharmacist of record of the applicant:

(a) Has obtained a permit by misrepresentation or fraud.

(b) Has attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation.

(c) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy.

(d) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud.

(e) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, since July 1, 2009.

(f) Has been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009.

(g) Has been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period.

(h) Has been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5-year period and the termination occurred at least 20 years before the date of the application.

(i) Is currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.

(j) Has dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466.

For felonies in which the defendant entered a plea of guilty or nolo contendere in an agreement with the court to enter a pretrial intervention or drug diversion program, the department shall deny the application if upon final resolution of the case the licensee has failed to successfully complete the program.

<u>If applicable to you, please provide the documentation to the Florida Board of Pharmacy.</u>

PHARMACY PERMIT APPLICATION CHECKLIST

Keep a copy of the completed application for your records.

It is recommended that you use the following checklist to help ensure that your application is complete. Failure to attach any required document, or to have required documentation sent to the Board, will result in an incomplete application. Final approval for inspection cannot be granted until the application is complete.

COMMUNITY PHARMACY PERMIT

_____All Application Questions Answered?

_____$255.00 Fee Attached (Permit fee includes $250 application fee and $5.00 unlicensed activity fee)

_____Articles of Incorporation paperwork from the Secretary of State provided?

_____PDM Designation and Privacy Statement Acknowledgement provided (Application Item #1)?

_____Affiliate/Owner Privacy Statement Acknowledgement provided for each affiliate/owner (Application Item #2)?

_____Applicant/Affiliate/Owner supplemental documents provided for explaining any previous ownership, disciplinary actions, voluntary relinquishments and/or criminal activity?

_____Applicant/Affiliate/Owner pharmacy permit questions answered and supplemental documents provided?

_____Policies and Procedures for preventing controlled substance dispensing based on fraudulent representations or invalid practitioner-patient relationships submitted?

FLORIDA BOARD OF PHARMACY
P.O. Box 6320
Tallahassee, FL 32314-6320
850-245-4292
http://www.floridaspharmacy.gov

COMMUNITY PHARMACY PERMIT

APPLICATION

Application Type – Please choose one of the following:

___New Establishment ($255.00 fee) **Complete: Section A only, along with Items #1 and 2.**	___ Change of Location ($100.00 fee) **Complete: Sections A and B only.**
___Change of Ownership ($255.00 fee) **Complete: Sections A and C only, along with Items #1 and 2.**	___ Stock Transfer (no fee) **Complete: Section A, pages 2-3 and Section D only.**

SECTION A. Please complete for all Application Types

Please list your Federal Employer Identification Number:

1. Corporate Name	Telephone Number
2. Doing Business As (d/b/a)	**E-Mail Address**** (see note below)

3. Mailing Address

City	**State**	**Zip**

4. Physical Address

City	**State**	**Zip**

5. Prescription Department Manager (PDM) Information

Name	License Number

Email Address ** (see note below)	Telephone Number
6. Contact Person	**Title**
Email Address ** (see note below)	**Telephone Number**

NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

7. Operating Hours

Is the pharmacy open at least 20 hours per week? Yes_____ No_____

8. Ownership Information

a. Type of Ownership: _____Individual _____Corporation _____Partnership

NOTE: If the applicant is a corporation or limited partnership you must include with your application a copy of the Articles of Incorporation on file with the Florida Secretary of State's office.

b. Are the applicants, officers, directors, shareholders, members and partners over the age of 18?

Yes _____ No _____

c. Does the corporation have more than $100 million of business taxable assets in this state? *If yes, provide attestation from Certified Public Accountant for previous tax year or Florida Corporate Income /Franchise and Emergency Excise Tax Return (F-1120).*

Yes _____ No _____

d. List all the owners and officers of the corporation. Each person listed below having an ownership interest of 5% or greater and any person who, directly or indirectly, manages, oversees, or controls the operation of the applicant including officers and members of the board of directors must submit a set of fingerprints and fees unless you answered yes to 8c. If 8c is "Yes", please list the owners below and only submit fingerprints for the Prescription Department Manager. If 8c is "Yes" and the prints are on file with DOH or AHCA and available to the Board of Pharmacy, the requirement to submit the prints for this person is met. Also, if the % of Ownership column does not add to 100%, please provide an explanation. *Attach a separate sheet if necessary.*

Owner/Officer-Title	Date of Birth	Mailing Address, City, State, Zip Code	% of Ownership
	/ /		%
	/ /		%
	/ /		%
	/ /		%
	/ /		%

9. Has anyone listed in 8.d had an ownership interest of 5% or more in a pharmacy or any other business permit which was disciplined, suspended, revoked, or closed involuntarily within the past 5 years? *If yes, please provide a signed statement disclosing the reason the entity was closed.*

Yes _____ No _____

9a. Has anyone listed in 8.d had an ownership interest of 5% or more in a pharmacy or any other business permit which was voluntarily relinquished or closed voluntarily within the past 5 years? *If yes, please provide a signed statement disclosing the reason the entity was closed.*

Yes _____ No _____

Pursuant to Section 465.022(5), Florida Statutes, questions 10 – 19 are being asked. If you answer "Yes" to any of the following questions, explain <u>on a separate sheet</u> providing accurate details and submit copies of supporting documentation.
10. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant obtained a permit by misrepresentation or fraud?
Yes _____ No_____
11. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant attempted to procure, or has procured, a permit for any other person by making, or causing to be made, any false representation?
Yes _____ No _____
12. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of, or the ability to practice, the profession of pharmacy?
Yes _____ No_____
13. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to health care fraud?
Yes_____ No_____
14. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under chapter 409, chapter 817, or chapter 893, or a similar felony offense committed in another state or jurisdiction, since July 1, 2009?
Yes _____ No_____
15. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 or 42 U.S.C. ss. 1395-1396 since July 1, 2009?
Yes _____ No _____
16. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause from the Florida Medicaid program pursuant to s. 409.913, unless the applicant has been in good standing with the Florida Medicaid program for the most recent 5-year period?
Yes _____ No _____
17. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program, unless the applicant has been in good standing with a state Medicaid program for the most recent 5-year period and the termination occurred at least 20 years before the date of the application?
Yes _____ No _____

18. Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health Human Services Office of Inspector General's List of Excluded Individuals and Entities? *(If yes, please submit proof.)*

Yes _____ No _____

19. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant dispensed any medicinal drug based upon a communication that purports to be a prescription as defined by s. 465.003(14) or s. 893.02 when the pharmacist knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship that includes a documented patient evaluation, including history and a physical examination adequate to establish the diagnosis for which any drug is prescribed and any other requirement established by board rule under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, or chapter 466?

Yes_____ No ___

20. Are you currently registered or permitted in any other states? *(If yes, provide the state, permit type and permit number for each permit. Attach a separate sheet if necessary.)*

Yes _____ No _____

State	Permit Type	Permit Number

21. Has the applicant, affiliated person, partner, officer, directors, or Prescription Department Manager ever owned a pharmacy? *(If yes, provide the name of the pharmacy, the state where the pharmacy is located and the status of the pharmacy. Attach a separate sheet if necessary.)*

Yes _____ No _____

Individual's Name	Pharmacy Name	State	Status

22. Has any disciplinary action ever been taken against any license, permit or registration issued to the applicant, affiliated person, partner, officer, director, or Prescription Department Msanager?

Yes _____ No _____

23. Has the applicant, affiliated person, partner, officer, or director ever been convicted of a felony or misdemeanor, excluding minor traffic convictions? You must include all misdemeanors and felonies, even if adjudication was withheld by the court, so that you would not have a record of conviction.

Yes _____ No _____

24. Does the applicant, affiliated person, partner, officer, director have any outstanding fines, liens or overpayments assessed by a final order of the department? If yes please answer 24a.

Yes _____ No _____

24a. Does the applicant, affiliated person, partner, officer, director have a repayment plan approved by the department?

Yes _____ No _____

25. Will the Pharmacy Dispense Schedule II and/or III Controlled Substances?

Yes _____ No _____

26. Will the Pharmacy act as a Central Fill Pharmacy?

Yes _____ No_____

27. Is the applicant, affiliated persons, partners, officers, or directors, under investigation or prosecution for a crime in any jurisdiction?

Yes _____ No_____

27a. Is the applicant, affiliated persons, partners, officers, or directors, under investigation or pending administrative action by the licensing authority of any jurisdiction, including its agencies and subdivisions?

Yes _____ No_____

SECTION B. Please complete for Change of Location only.

1. Current Practice Location Address

City	State	Zip

E-Mail Address** (see note below)	Telephone Number

2. New Practice Location Address

City	State	Zip

E-Mail Address** (see note below)	Telephone Number

Please provide your existing Pharmacy Permit Number:

Please provide your existing federal DEA Number:

NOTE:* Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.*

SECTION C. Please complete for Change of Ownership only.

1. Are you changing physical locations with this change of ownership?

Yes _____ No _____ *NOTE: If yes, please complete **Section B** above.*

2. Please provide date when business transaction for the change of ownership will be completed?

Date: _____

3. Do you have a signed letter from both the buyer and seller which indicates dates that pharmacy permit license should be transferred? *NOTE: A copy of the signed letter should be provided with your application.*

Yes _____ No _____

SECTION D. Please complete for Stock Transfer of Ownership Interests only.

1. Please provide the date when the transfer of ownership interest took place?

Date: _____

2. Did your company's FEIN change as a result of the transfer of ownership interest referenced in Section D, Question 1 above?

Yes _____ No _____ *NOTE: If yes, please complete **Section C** above and include necessary fee.*

ALL QUESTIONS MUST BE ANSWERED OR YOUR APPLICATION WILL BE RETURNED

****

Section 456.013(1), F.S., requires that applicants supplement their applications as needed to reflect any material change in any circumstances or conditions stated in the application, which takes place between the initial filing of the application and the final grant or denial of the license, which might affect the decision of the department.

I swear or affirm that the statements contained in this application are true, complete, and correct and I agree that said statements shall form the basis of my application and I do authorize the Florida Board of Pharmacy to make any investigations that they deem appropriate and to secure any additional information concerning me, and I further authorize them to furnish any information they may have or have in the future concerning me to any person, corporation, institution, association, Board, or any municipal, county, state, or federal governmental agencies or units, and I understand according to the Florida Board of Pharmacy Statutes that a Pharmacy Permit may be revoked or suspended for presenting any false, fraudulent, or forged statement, certificate, diploma, or other item, in connection with an application for a license or permit, as set forth in Section 465.015(2)(a), F.S.

Under penalty of perjury I have read the foregoing document and that the facts stated in it are true. I recognize that providing false information may result in disciplinary action against my license or criminal penalties.

SIGNATURE _____ DATE_____
(Owner or officer of establishment)

FLORIDA DEPARTMENT OF LAW ENFORCEMENT

NOTICE FOR APPLICANTS SUBMITTING FINGERPRINTS WHERE CRIMINAL RECORD RESULTS WILL BECOME PART OF THE CARE PROVIDER BACKGROUND SCREENING CLEARINGHOUSE

NOTICE OF:

- **SHARING OF CRIMINAL HISTORY RECORD INFORMATION WITH SPECIFIED AGENCIES,**
- **RETENTION OF FINGERPRINTS,**
- **PRIVACY POLICY, AND**
- **RIGHT TO CHALLENGE AN INCORRECT CRIMINAL HISTORY RECORD**

This notice is to inform you that when you submit a set of fingerprints to the Florida Department of Law Enforcement (FDLE) for the purpose of conducting a search for any Florida and national criminal history records that may pertain to you, the results of that search will be returned to the Care Provider Background Screening Clearinghouse. By submitting fingerprints, you are authorizing the dissemination of any state and national criminal history record that may pertain to you to the Specified Agency or Agencies from which you are seeking approval to be employed, licensed, work under contract, or to serve as a volunteer, pursuant to the National Child Protection Act of 1993, as amended, and Section 943.0542, Florida Statutes. "Specified agency" means the Department of Health, the Department of Children and Family Services, the Division of Vocational Rehabilitation within the Department of Education, the Agency for Health Care Administration, the Department of Elder Affairs, the Department of Juvenile Justice, and the Agency for Persons with Disabilities when these agencies are conducting state and national criminal history background screening on persons who provide care for children or persons who are elderly or disabled. The fingerprints submitted will be retained by FDLE and the Clearinghouse will be notified if FDLE receives Florida arrest information on you.

Your Social Security Number (SSN) is needed to keep records accurate because other people may have the same name and birth date. Disclosure of your SSN is imperative for the performance of the Clearinghouse agencies' duties in distinguishing your identity from that of other persons whose identification information may be the same as or similar to yours.
Licensing and employing agencies are allowed to release a copy of the state and national criminal record information to a person who requests a copy of his or her own record if the identification of the record was based on submission of the person's fingerprints. Therefore, if you wish to review your record, you may request that the agency that is screening the record provide you with a copy. After you have reviewed the criminal history record, if you believe it is incomplete or inaccurate, you may conduct a personal review as provided in s. 943.056, F.S., and Rule 11C8.001, F.A.C. If national information is believed to be in error, the FBI should be contacted at 304-625-2000. You can receive any national criminal history record that may pertain to you directly from the FBI, pursuant to 28 CFR Sections 16.30-16.34. You have the right to obtain a prompt determination as to the validity of your challenge before a final decision is made about your status as an employee, volunteer, contractor, or subcontractor.

Until the criminal history background check is completed, you may be denied unsupervised access to children, the elderly, or persons with disabilities.

The FBI's Privacy Statement follows on a separate page and contains additional information.

US Department of Justice, Federal Bureau of Investigation,
Criminal Justice Information Services Division

Privacy Statement

Authority: The FBI's acquisition, preservation and exchange of information requested by this form is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include numerous Federal statutes, hundreds of State statutes pursuant to Pub.L.92-544, Presidential executive orders, regulations and/or orders of the Attorney General of the United States, or other authorized authorities. Examples include, but are not limited to: 5 U.S.C. 9101; Pub.L.94-29; Pub.L.101-604; and Executive Orders 10450 and 12968. Providing the requested information is voluntary; however, failure to furnish the information may affect timely completion of approval of your application.

Social Security Account Number (SSAN): Your SSAN is needed to keep records accurate because other people may have the same name and birth date. Pursuant to the Federal Privacy Act of 1974 (5 USC 552a), the requesting agency is responsible for informing you whether disclosure is mandatory or voluntary, by what statutory or other authority your SSAN is solicited, and what uses will be made of it. Executive Order 9397 also asks Federal Agencies to use this number to help identify individuals in agency records.

Principal Purpose: Certain determinations, such as employment, security, licensing and adoption, may be predicated on fingerprint based checks. Your fingerprints and other information contained on (and along with) this form may be submitted to the requesting agency, the agency conducting the application investigation, and/or FBI for the purpose of comparing the submitted information to available records in order to identify other information that may be pertinent to the application. During the processing of this application, and for as long hereafter as my be relevant to the activity for which this application is being submitted, the FBI(may disclose any potentially pertinent information to the requesting agency and/or to the agency conducting the investigation. The FBI may also retain the submitted information in the FBI's permanent collection of fingerprints and related information, where it will be subject to comparisons against other submissions received by the FBI. Depending on the nature of your application, the requesting agency and/or the agency conducting the application investigation may also retain the fingerprints and other submitted information for other authorized purposes of such agency(ies).

Routine Uses: The fingerprints and information reported on this form may be disclosed pursuant to your consent, and may also be disclosed by the FBI without your consent as permitted by the Federal Privacy Act of 1974 (5 USC 552a(b)) and all applicable routine uses as many be published at any time in the Federal Register, including the routine uses for the FBI Fingerprint Identification Records System (Justice, FBI-009) and the FBI's Blanket Routine Uses (Justice/FBI-BRU). Routine uses include, but are not limited to, disclosures to: appropriate governmental authorities responsible for civil or criminal law enforcement counterintelligence, national security or public safety matters to which the information may be relevant; to State and local governmental agencies and nongovernmental entities for application processing as authorized by Federal and State legislation, executive order, or regulation, including employment, security, licensing, and adoption checks; and as otherwise authorized by law , treaty, executive order, regulation, or other lawful authority. If other agencies are involved in processing the application, they may have additional routine uses.

Additional Information: The requesting agency and/or the agency conducting the application investigation will provide you additional information pertinent to the specific circumstances of this application, which may include identification of other authorities, purposes, uses, and consequences of not providing requested information. In addition, any such agency in the Federal Executive Branch has also published notice.

Electronic Fingerprinting

Take this form with you to the Live Scan service provider. Please check the service provider's requirements to see if you need to bring any additional items.

- Background screening results are obtained from the Florida Department of Law Enforcement and the Federal Bureau of Investigation by submitting to a fingerprint scan using the Livescan method;
- You can find a Livescan service provider at: http://www.floridahealth.gov/licensing-and-regulation/background-screening/livescan-service-providers.html
- Failure to submit background screening will delay your application;
- Applicants may use any Livescan service provider approved by the Florida Department of Law Enforcement to submit their background screening to the department;
- If you do not provide the correct Originating Agency Identification (ORI) number to the livescan service provider the Board office will not receive your background screening results;
- You must provide accurate demographic information to the livescan service provider at the time your fingerprints are taken, ***including your Social Security number (SSN)***;
- The ORI number for the Board of Pharmacy is **EDOH4680Z.**
- Typically background screening results submitted through a Livescan service provider are received by the Board within 24-72 hours of being processed.
- If you obtain your livescan from a service provider who does not capture your photo you may be required to be reprinted by another agency in the future.

Name:_____ SSN#: _____ - ____ - _____

Aliases:_____

Address:_____Apt. Number:_____

City:_____ State: _____Zip Code: _____

Date of Birth: _____/_____/_____ Place of Birth: _____
(MM/DD/YYYY)

Weight: _____ Height: _____ Eye Color:_____ Hair Color: _____

Race: _____
(W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: _____
(M=Male; F=Female)

Citizenship: _____

Transaction Control Number (TCN#):_____
(*This will be provided to you by the Live Scan Service provider.*)

Keep this form for your records.

Item #1- PDM Designation and Privacy Statement Acknowledgement

File #: (if known):
License #: (if applicable):

To: Florida Board of Pharmacy
Post Office Box 6320
Tallahassee, FL 32314-6320
(850) 245-4292- phone
(850) 413-6982 - fax
MQAPharmPDMAffiliate@flhealth.gov

Section A. Prescription Department Manager (PDM) Designation

Applicant/Pharmacy Name:		
Applicant/Pharmacy Mailing Address:		
City	**State**	**Zip**
Incoming PDM Name:		**License#:**
		PS
Date Beginning as PDM:	**Incoming PDM Signature**	

PDM Transaction Control Number (TCN) – related to Livescan Fingerprints *(optional, if known)*:
** For more information regarding Livescan Fingerprints to: http://flhealthsource.gov/bgs-faqs**

****OPTIONAL: Only provide following information if there is an Outgoing PDM at current pharmacy****

Outgoing PDM Name:		**License#:**
		PS
Date Ending as PDM:	**Outgoing PDM Signature** *(optional)*	

Section B. Incoming PDM Privacy Statement Acknowledgement

Note: Acknowledgment should be completed by same person listed in Section A above as Incoming PDM.

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

Date:	**Incoming PDM Signature**

Item #2- Affiliate/Owner Privacy Statement Acknowledgement

To be completed by EACH Affiliate/Owner listed in the application.

To: **Florida Board of Pharmacy, Post Office Box 6320, Tallahassee, FL 32314-6320**
(850) 245-4292- phone * (850) 413-6982 – fax * MQAPharmPDMAffiliate@flhealth.gov

From:

Affiliate / Owner Name:		**File # (required):**
Applicant Name:		
Affiliate/Owner Mailing Address:		
City	**State**	**Zip**
Affiliate/Owner E-Mail ** (see note below)	**Affiliate/Owner Telephone Number**	
Affiliate/Owner Transaction Control Number (TCN) *(optional, if known)*: ** For more information regarding Livescan Fingerprints to: http://flhealthsource.gov/bgs-faqs**		
NOTE: Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.		

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the "Privacy Statement" document from the Federal Bureau of Investigation."

Affiliate/Owner Signature (Required) **Date (of signature)**