Division of Professional Licensing
UTAH DEPARTMENT OF COMMERCE

Dispensing Medical Practitioner Clinic Pha

Clear Form

APPLICANT INFORMATION

Clinic Name: _____

DBA(s) *if applicable*: _____

DBA Registration Number(s): _____

Utah Division of Corporations Registration Number: _____

IRS Employee ID Number (EIN): _____

Address: _____

City: _____ State: _____ Zip: _____

Location Phone: (_____) _____ – _____ Email: _____

Note: All Division notices and communication will be sent to this email.

Contact Person: _____ _____ _____

First *Middle* *Last*

Contact Person Phone: (____) _____ – _____ Email: _____

AFFIDAVIT AND RELEASE

I understand that in all areas of this application the words "you", "I" and "applicant" apply to the entity listed above and *all* subsidiaries, owners, officers, managers, qualifiers and prior entities for which these individuals have been involved.

I certify that to the best of my knowledge, the information contained in the application and all supporting document(s) are true and correct, and discloses all material facts regarding the applicant, and that I will update or correct the application as necessary, prior to any action on my application.

I authorize all persons, organizations, governmental agencies, or any others not specifically listed, which are set forth directly or by reference in this application, to release to the Department of Commerce, State of Utah, any files, records, or information of any type reasonably required for the Department to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

I understand that it is the continuing responsibility of applicants and licensees to read, understand, and apply the requirements contained in all statutes and rules pertaining to the occupation or profession for which I am applying, and that failure to do so may result in civil, administrative, or criminal sanctions.

I understand that I am responsible to update the Department of any changes relating to my application/license/certification/registration.

I understand that if the application is not complete at the time of submission, it will delay approval and could result in a denial.

I declare under criminal penalty under the law of Utah that this application is true and correct.

Authorized Signature: _____ Date: _____

Printed Name: _____ Title/Position: _____

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PRIVACY NOTICE

The information you provide on this form will be used to determine your eligibility for a license, registration, or certification in Utah. Failure to provide complete information as requested will result in the denial of your request as incomplete.

Information provided in this form is retained in accordance with state record retention laws. For specific information about the records retention for this form, please visit https://dopl.utah.gov/records

To comply with legal and regulatory requirements, we may share limited information about your license, registration, or certification with authorized parties. This may include government agencies, national databases, and contracted vendors. Shared information may include issue date, status, expiration date, disciplinary actions, and your name or other direct identifiers.

We may also share aggregated and de-identified data (e.g., education levels, exam pass rates, length of licensure, etc.) with relevant stakeholders for data analysis and reporting purposes.

ACKNOWLEDGEMENT:

Your signature acknowledges receipt of this information.

Authorized Signature: _____ Date: _____

Legal Business Name: _____

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REASON FOR APPLICATION

Select all that apply

NOTE: that a Surrender Form is required for Change of Name, Change of Location, or Change of Ownership

☐ **New Facility** — Anticipated Open Date:_____

☐ **Change of Name** — Utah License Number: _____
Current Name: _____
Effective Date of Change:_____

☐ **Change of Location** — Utah License Number: _____
Current Address:_____
Proposed Date of Change: _____

☐ **Change of Ownership**
Dispensing Medical Practitioner Clinic — Utah License Number: _____
Effective Date of Change:_____

BUSINESS ENTITY ORGANIZATION

Please select entity type:

- ☐ Corporation
- ☐ Business Trust
- ☐ General Partnership
- ☐ Limited Liability Company
- ☐ Limited Partnership
- ☐ Limited Liability Partnership
- ☐ Sole Proprietorship

If registered as sole proprietorship, complete the section below.

SOLE PROPRIETORSHIP APPLICANTS ONLY

Full Legal Name: _____ _____ _____
First Middle *Last*

All Previous Legal Names: _____

Other DOPL Licenses Held: _____

SSN:* _____ Date of Birth: _____
** If you don't have a social security number, please follow the instructions on the last page.*

Please select one:

- ☐ I am a United States citizen or a non-citizen of the United States who is lawfully present.
- ☐ I am a foreign national not physically present in the United States.
- ☐ None of the above, please explain: _____

Driver License or State ID Card: _____ _____ _____
State of Issue *License Number* *Expiration Date*

NOTE: *If you do not hold a US Driver License or a US State ID, you must present a legible copy of your current and valid government issued document(s) showing evidence of lawful presence in the United States.*

DISPENSING MEDICAL PRACTITIONER IN-CHARGE (DMPIC)

Full Legal Name: _____ _____
First *Middle* *Last*

Address: _____ City: _____State: _____ Zip: _____

License Number: _____ Type: _____ State of Issue: _____

Business Name: _____
**Note: If you are a Sole Proprietor, this is your full legal name.*

Address: _____ City: _____State: _____ Zip: _____

I understand that as the **Dispensing Medical Practitioner In-Charge (DMPIC)**, licensed under Utah Code § 58-17b, as a Dispensing Medical Practitioner working with this Dispensing Medical Practitioner Clinic Pharmacy, I am designated by this dispensing medical practitioner clinic pharmacy to be responsible for *all* activities of the pharmacy.

I am familiar with my legal obligations under Utah Code § 58-17b-804 and Utah Administrative Code § R156-17b-603 and any others Rights, Responsibilities and Obligations enumerated under Utah or Federal Law. I understand that it is my responsibility to know the laws and rules governing this dispensing medical practitioner clinic pharmacy.

DMPIC Signature: _____ Date: _____

DISPENSING SUBTYPES

Please select the drug(s) approved under Utah Code § 58-17b-803 that will be dispensed (*attach a separate sheet if necessary*):

Please select the type of drug to be dispensed (check all that apply).

- ☐ Cosmetic Drugs
- ☐ Injectable Weight Loss Drugs
- ☐ Cancer Drug Treatment Regimen
- ☐ Prepackaged Drugs *(Employer Sponsored Clinic)*
- ☐ Hormonal based contraception *(except injectable or implantable methods);*
- ☐ Hydroquinone up to 4%;
- ☐ Tretinoin up to 0.1%;

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INSPECTION REFERRAL

Clinic Name: _____

Address: _____ City: _____ State: _____ Zip: ____

Phone: (_____) _____ – _____ Fax: (_____) _____ – _____

Responsible Dispensing Practitioner:

Name: _____ _____ License Number: _____
First Last

Phone: (_____) _____ – _____ Email: _____

Local Pharmacy Contact:

Name: _____ _____ License Number: _____
First Last

Phone: (_____) _____ – _____ Email: _____

Date Beginning Operations: _____ Hours of Operation: _____

I acknowledge the Division's authority to inspect the licensee's business premises pursuant to Utah Code § 58-17b-103. I understand that all entities licensed under Utah Code § 58-17b-302 shall comply with all state and federal laws and regulations relating to the practice of pharmacy, and that by making this application for licensure, attest to full compliance with said laws.

I acknowledge that whenever an applicable statute or rule requires or prohibits action by a pharmacy, the responsible individual and the owner of the pharmacy shall be responsible for all activities of the pharmacy, regardless of the form of the business organization.

I understand that a conditional pharmacy license may be issued to this pharmacy pending inspection and verification of compliance with the operating standards that apply to the practice of pharmacy. The outcome of the inspection is necessary to determine whether all licensure requirements are met, and a conditional pharmacy license is not renewable.

I attest that the information contained in this application is truthful, correct and complete. I understand that it is unlawful and punishable as a Class A Misdemeanor to deal with DOPL or the Licensing Board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

Signature of Responsible Individual: _____ Date: _____

For Official Use Only

License Number(s): _____ Expiration: _____

Licensing Specialist: _____ Date of Referral: _____

Notes:

APPLICATION CHECKLIST AND INSTRUCTIONS

NOTE: *Incomplete applications will be denied.*

Your application is classified as a public record and may be available for inspection by the public, except with regard to the release of information which is sub-classified as controlled, private, or protected under the Government Records Access and Management Act or restricted by other law.

If you do not have a valid Social Security number, you must submit your Individual Taxpayer Identification Number (ITIN), Alien Registration Number (A-number), or a copy of an unexpired government issued passport from your country of residence and an intent-to-hire letter from a Utah based employer (Utah Code § R156-1-301). Submission of the above documents may require additional documents to demonstrate lawful presence (Utah Code § 63G-12-402 (3)(k)).

ALL APPLICANTS

The following items are required to complete your application:

- ☐ $200.00 non-refundable application-processing fee, made payable to "DOPL".
- ☐ Completed "Dispensing Medical Clinic Inspection Referral" on page 4 of this application.

CANCER DRUG TREATMENT REGIMEN APPLICANTS

- ☐ Submit documentation of *each* **Dispensing Medical Practitioner**'s medical oncology certification or eligibility.

Return completed application to:

In person or via express delivery:
Division of Professional Licensing
Heber M Wells Building
160 E 300 S
Salt Lake City, UT 84111

US Postal Service:
Division of Professional Licensing
PO BOX 146741
Salt Lake City, UT 84114-6741

If you have questions, please contact the Division via our direct email address, b3@utah.gov or via the phone or fax listed below.