Division of Professional Licensing
UTAH DEPARTMENT OF COMMERCE

Remote Dispensing Pharmacy:

Select One: ☐ Class A ☐ Class B

Clear Form

APPLICANT INFORMATION

Business Name: _____
**Note: If you are a Sole Proprietor, this is your full legal 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 of Existing Pharmacy** — 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.*

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QUALIFYING QUESTIONNAIRE

Do not leave any question blank.

DOPL may request additional documentation if the information submitted is insufficient.

1. ☐ Yes ☐ No	Have you EVER had a license, certificate, permit, or registration to practice a regulated profession denied, conditioned, curtailed, limited, restricted, suspended, revoked, reprimanded, resigned, or surrendered while under investigation, or otherwise **disciplined in any way**?
2. ☐ Yes ☐ No	Do you CURRENTLY have **any criminal action active or pending**?
3. ☐ Yes ☐ No	WITHIN THE PAST 10 YEARS, have you pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a **misdemeanor** in any jurisdiction?
4. ☐ Yes ☐ No	Have you EVER pled **guilty** to, **no contest** to, entered into a **plea in abeyance**, or been **convicted** of a felony in any jurisdiction?

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. If you answered "Yes" to questions 2, 3, or 4 you must submit the following for EACH and EVERY incident:

- **personal account of the incident**
- **police report(s)**
- **court record(s)**
- **probation/parole officer report(s)**

If you are unable to obtain any of the records required above, you must submit documentation on official letterhead from the police department and/or court indicating that the information is no longer available.

Please **DISCLOSE** the following:

- charges that were later held in abeyance (plea in abeyance), diverted, reduced, or dismissed.
- motor vehicle offenses such as driving while impaired or intoxicated.
- if you are restricted from possession, purchase, transfer, or ownership of a firearm or ammunition (even if your restriction is based on a non-reportable juvenile conviction).

You do **NOT** need to disclose:

- minor traffic offenses such as parking or speeding violations.
- juvenile offenses, unless you were tried as an adult.
- legally expunged or sealed criminal history incidents.

For more information, see DOPL's criminal history FAQs.

PROFESSIONAL LICENSES

Do you currently hold, or have you ever held, a license, certification, or registration to practice any occupation or profession in Utah or any other jurisdiction? . *(Use additional sheets if necessary.)*

Profession:_____ **License Number:** _____

Issuing State: _____ **License Status:**_____ **Issue Date:** _____

Profession:_____ **License Number:** _____

Issuing State: _____ **License Status:**_____ **Issue Date:** _____

Profession:_____ **License Number:** _____

Issuing State: _____ **License Status:**_____ **Issue Date:** _____

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MEDICAL QUALIFYING QUESTIONNAIRE

Read thoroughly and answer each question. Do not leave any question blank.

A "yes" answer does not necessarily mean you will not be granted a license; however, DOPL may request additional documentation if the information submitted is insufficient.

1. Have your rights, privileges, and/or participation ever been denied, conditioned, curtailed, limited, restricted, suspended or revoked in any way by:
   - ☐ Yes ☐ No a hospital or health care facility
   - ☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
   - ☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
   - ☐ Yes ☐ No malpractice insurance coverage
   - ☐ Yes ☐ No other entity: _____

2. Have you ever been permitted to resign or surrender any rights, privileges and/or participation while under investigation or while action was pending against you from:
   - ☐ Yes ☐ No a hospital or health care facility
   - ☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
   - ☐ Yes ☐ No The Federal Drug Enforcement Administration or any state drug enforcement agency
   - ☐ Yes ☐ No malpractice insurance coverage
   - ☐ Yes ☐ No other entity: _____

3. Is any action pending against you now by:
   - ☐ Yes ☐ No a hospital or health care facility
   - ☐ Yes ☐ No Medicaid, Medicare or any other state or federal health care payment reimbursement program
   - ☐ Yes ☐ No the Federal Drug Enforcement Administration or any state drug enforcement agency
   - ☐ Yes ☐ No malpractice insurance coverage
   - ☐ Yes ☐ No other entity: _____

4. ☐ Yes ☐ No Have you been named as a defendant in a malpractice suit?

5. ☐ Yes ☐ No Have you ever had office monitoring, practice curtailments, individual surcharge assessments based upon specific claims history, or other limitation, restrictions or conditions imposed by any malpractice carrier?

If you answered **"Yes"** to question 4, you must submit a complete narrative of the circumstances and a National Practitioner Data Bank report outlining all professional liability claims made against your license and any settlements paid by or on your behalf. *NPDB website:* http://www.npdb.hrsa.gov.

If you answered "Yes" to any of the above questions, enclose with this application complete information with respect to all circumstances and the final result, if such has been reached.

NATIONAL PROVIDER IDENTIFIER (NPI)

Your NPI: *(if applicable)* _____

CONTROLLED SUBSTANCE LICENSE (optional)

If you are applying for a controlled substance license, you must read and sign the affidavit below.

1. I have reviewed and understand that I must abide by the additional laws and rules that govern the practice of my profession as it pertains to controlled substances.
2. I understand that there may be additional continuing education requirements for those who hold a controlled substance license.
3. I understand it is required that I hold a valid Federal Drug Enforcement Administration (DEA) registration.

Signature of Applicant:_____ Date: _____

Note: *In addition to signing this affidavit, you must complete the items listed on the CONTROLLED SUBSTANCE LICENSE checklist at the end of this application to obtain a Controlled Substance License.*

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REMOTE DISPENSING PHARMACIST-IN-CHARGE

NOTE: *In addition to completing this section, you must submit two completed fingerprint cards for the RDPIC; see https://dopl.utah.gov/fingerprints.html for information.*

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

License Number _____ State of Issue:_____

Address: _____

City:_____ State: _____ Zip:_____

Phone: (_____) _____ – _____ Email: _____

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 Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/registration by the State of Utah.

PIC Signature: _____ Date: _____

SUPERVISING PHARMACY

Pharmacy Name: _____

Pharmacy License Number:_____ Issuing State:_____

Class: ☐ Class A ☐ Class B

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

Phone: (_____) _____ – _____ Email: _____

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PHARMACIST IN CHARGE

NOTE: *In addition to completing this section, you must submit two completed fingerprint cards for the Pharmacist In Charge (PIC). See the information below and the checklist at the end of this application for more information.*

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

Mailing Address: _____ City: _____ State: _____ Zip:_____

License Number _____ State of Issue:_____

By signing below, 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 Division of Occupational and Professional Licensing, State of Utah, any files, records, or information of any type reasonably required for the Division to properly evaluate my qualifications for licensure/certification/ registration by the State of Utah.

Fingerprints submitted with this application are used to complete a search through the files of the Utah Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigations (FBI). Prior to submitting fingerprints, you must read and acknowledge, by signing the affidavit below, the Privacy Act Statement found at: https://www.fbi.gov/services/cjis/compact-council/privacy-act-statement . Physical copies of this statement may also be obtained upon request from the Division.

The criminal record information obtained by this search will be used by Division staff to evaluate your ability to obtain licensure in Utah. You may challenge or review your criminal record. For additional information regarding the challenge or review process, please see below.

By signing below, you acknowledge receipt of this information and consent to the background check process described above.

Signature: _____ Date: _____

Pharmacy Name: _____

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

Please see our website, www.dopl.utah.gov/fingerprints.html, for required information and approved locations to obtain fingerprints.

Completed fingerprint cards can be mailed to:
Division of Professional Licensing
P.O. Box 146741
Salt Lake City, UT 84114-6741

REVIEW OF YOUR CRIMINAL RECORD: If you wish to review or challenge the accuracy of the information in your FBI record, you should contact the agency that contributed the information in question. You may also direct the challenge to the FBI. Please see their website at: https://www.fbi.gov/services/cjis/identity-history-summary-checks. You may also contact them via mail at: FBI: CJIS Division, Attn. Criminal History Analysis Team 1, 1000 Custer Hollow Road, Clarksburg, WV 26306. The FBI will forward the challenge to the respective agency.

If you wish to review or challenge the accuracy of the information in your BCI record, you must complete the required "Record Challenge Form", available at: https://bci.utah.gov/criminal-records/criminal-records-forms/, and submit it directly to BCI.

Agency review of a licensing decision based on your criminal record may be obtained by filing a written request for agency review with the Executive Director of the Department of Commerce within thirty (30) days after notification of the decision. Any such request must comply with the requirements of Utah Code § 63G-4-301 and Utah Admin. Code R151-4-902.

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DISCLOSURE OF NATURE OF BUSINESS

Describe the nature of business and how your operating standards meet Utah Admin. Code R156-17b-614g.

Include the following:

- ☐ Detailed description of how location is in an area of need, as defined in Utah Admin. Code R156-17b-102(4).
- ☐ Description of physical facility where remote dispensing pharmacy will operate.
- ☐ List of qualified pharmacy technicians to staff the remote dispensing pharmacy.
- ☐ Description of tele pharmacy system.

Attach additional sheets as necessary.

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REMOTE DISPENSING PHARMACY – INSPECTION REFERRAL

Remote Dispensing Pharmacy:

Name: _____

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

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

Remote Dispensing Pharmacist-in-charge:

Name: _____ _____ License Number: _____
First *Last*

Phone: (_____) _____ – _____ Email: _____

Local Pharmacy Contact:

Name: _____ _____ License Number: _____
First *Last*

Phone: (_____) _____ – _____ Email: _____

Supervising Pharmacy Name: _____

Pharmacy License Number: _____ Issuing State: _____ Classification: ☐ A ☐ B

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

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:

BEFORE THE
DIVISION OF PROFESSIONAL LICENSING
DEPARTMENT OF COMMERCE OF THE STATE OF UTAH

IN THE MATTER OF THE LICENSE(S) ISSUED TO: _____

PHARMACY LICENSE NUMBER: _____

CONTROLLED SUBSTANCE LICENSE NUMBER: _____

TO ACT AS A: _____ PHARMACY WITHIN THE STATE OF UTAH.
(License Classification)

LICENSEE and the DIVISION OF PROFESSIONAL LICENSING ("Division") of the Utah Department of Commerce, upon acceptance by the Division agree as follows:

1. Licensee hereby tenders its license as a _____ Pharmacy to the Division, informing the Division that it wishes to surrender it to the Division.

2. Licensee affirms that it is offering to surrender its license because of the closure of the Pharmacy on:

Month: _____ Day: _____ Year: _____

That such closure is due to a change in (please check one):

☐ NAME ☐ LOCATION ☐ OWNERSHIP ☐ N/A (Specify) _____

3. Licensee admits the jurisdiction of the Division over it and over the subject matter of its request.

4. Licensee affirms that it is offering to surrender its license voluntarily of its own free will and choice without any undue inducement, coercion, or threat from any source, and that the only promises or under understandings it has obtained from the Division regarding the surrender of its license are those contained in this Agreement.

5. This agreement is not a finding of unprofessional or unlawful conduct nor is it disciplinary action against the Licensee. The Division retains any jurisdiction to subsequently initiate disciplinary proceedings for any conduct the Licensee may have engaged in prior to the date of this agreement or may engage in subsequent to the date of this agreement.

6. Licensee understands that it will not receive any refund of license or renewal fees previously paid to the Division.

7. Licensee agrees to remove any type of pharmacy advertising which would constitute a violation of Utah Code Ann. § 58-17b-501 (3)(b).

8. Licensee affirms that notification to the Division and compliance has been made as required in Utah Administrative Code R156-17b-604 and Utah Code Annotated § 58-17b-614.

9. If the surrender of a license(s) by the Licensee is due to a name change, change in ownership or location which will take place subsequent to the issuance of a new license(s), the Licensee affirms that, upon the Divisions, issuance of the new license(s), the Licensee will within 10 days surrender to the Division the former license(s) by completing this form and submitting it to the Division.

10. Licensee affirms the original Pharmacy licenses are attached and included with this document.

11. The undersigned affirms that they have the authority to enter into this agreement on behalf of the Licensee.

Licensee Owner/Responsible Agent: _____ Date: _____

Printed Name: _____ Title: _____

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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 Admin. Code R156-1-301). Submission of the above documents may require additional documents to demonstrate lawful presence (Utah Code § 63G-12-402 (3)(k)).

Remote Dispensing Pharmacy is defined as a pharmacy located in Utah that serves as the originating site where patient receiving services through a tele pharmacy system is physically located and the practice of tele pharmacy occurs. This pharmacy application should not be submitted to DOPL until the facility is substantially completed and is within six weeks of the anticipated date of opening.

ALL APPLICANTS

All applicants are required to submit the following items to complete the application:

- ☐ $232.00 non-refundable application-processing fee and non-refundable Fingerprint Processing fee for the Remote Dispensing PIC payable to "DOPL".
- ☐ Fingerprints, two sets, to be used by DOPL for a fingerprint search through the files of the Utah Bureau of Criminal Identification (BCI) and the Federal Bureau of Investigations (FBI). Please see our website, www.dopl.utah.gov/fingerprints.html, for required information and approved locations to obtain fingerprints.
- ☐ Supporting documentation for any "yes" answers provided on the qualifying questionnaires.
- ☐ Completed "Pharmacy Inspection Referral" found in this application.
- ☐ Surrender Form if application is due to Change of Name, of Location, or of Ownership.

OPTIONAL CONTROLLED SUBSTANCE LICENSE

If your practice will include dispensing controlled substances to any person other than an inpatient in a licensed health care facility, you must apply for a Utah Controlled Substance License by submitting the following:

- ☐ $100.00 non-refundable application-processing fee, made payable to "DOPL".
- ☐ Complete the "Utah Controlled Substance Law and Rule Affidavit" found on page 5 of this application.
- ☐ Completed "Controlled Substance Database Questionnaire" found on page 6 of this application

***NOTE:** In addition to the Utah Controlled Substance License, you must hold a valid **Federal Drug Enforcement Administration (DEA)** registration.*

Submit the above items with your completed application to:

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

By in-person or express delivery:
Division of Professional Licensing
Heber M Wells Building, 1st Floor
160 E 300 S
Salt Lake City, UT 84114

If you have questions, please contact the Division at 801-530-6628 or by email: b3@utah.gov.

Applications are not accepted by email.