

INSPECTION REFERRAL

Clinic Name: _____

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

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Responsible Dispensing Practitioner:

Name: _____ License Number: _____
 First *Last*

Phone: (_____) _____ - _____ Email: _____

Local Clinic 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: _____

<i>For Official Use Only</i>	
License Number(s): _____	Expiration: _____
Licensing Specialist: _____	Date of Referral: _____
Notes: _____	