GEORGIA BOARD OF PHARMACY
2 MLK Jr. Drive, SE, 11th Floor
East Tower
Atlanta, GA 30334
(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**

INFORMATION SHEET FOR FILING AN APPLICATION FOR PHARMACY LICENSE

- The **required non-refundable application fee** must accompany the completed application. The fee for checks returned due to non-sufficient funds is $30.00.

- **SUBMIT APPLICATION IN A 9x12 or LARGER ENVELOPE** – Do not staple pages or check/money order.

- The Board of Pharmacy requires an inspection of any pharmacy facility **located within the State of Georgia** prior to the issuance of a license. The request for the **inspection** should be made with the **Georgia Drugs and Narcotics Agency (GDNA)** by the applicant after submitting the completed application to the Board office. You may contact GDNA at (404) 656-5100 or (800) 656-6568. Do ***not*** contact GDNA for an inspection until you are notified by the Board that your application has been processed; GDNA will not inspect or set up an inspection without a processed application.

- **Allow a minimum of 60 business days for the processing of an application.**

- The Board staff cannot provide legal advice, interpretations of the laws and rules, and cannot advise you as to which type of license your business should apply for; you will need to seek private legal counsel to assist you regarding these matters.

- Please refer to Georgia law and Board rules regarding the requirement for the license type for which you are applying. These may be found on the Board's website at: **www.gbp.georgia.gov**.

- **Georgia issues permits for non-resident retail pharmacies; but applicants may only apply for permits using the non-resident pharmacy permit application.**

- **For Research Applicants – registration for those who plan to obtain, possess, or conduct research, teaching, analysis or drug dog detection/training with controlled substances:** The primary individual in charge/responsible for the protocol for the program MUST provide with the application evidence of US citizenship (copy of birth certificate or passport) or qualified alien status under the Work Opportunity and Personal Responsibility Act of 1996. **List the physical address as where the drugs are stored that are used for research; including room numbers.**

- **For Wholesalers, Third-Party Logistics Providers and Reverse Distributors Applicants:** Wholesalers, Third-Party Logistics Providers and Reverse Distributors within the State of Georgia are required, by law to be licensed with the Georgia State Board of Pharmacy. Wholesalers or Reverse Distributors located outside the State of Georgia, but wholesale, distribute, or supply drugs to individuals or facilities within the State of Georgia, are also required by law to be licensed with the Georgia State Board of Pharmacy. Third-Party Logistics Providers located outside the State of Georgia are **NOT** required to be licensed with the Georgia State Board of Pharmacy.
- A GDNA inspection is **not** required for out-of-state facilities (i.e., wholesalers). GDNA will process the personal certification forms that wholesalers, manufacturers and reverse distributors submit with their applications.

- **Oxygen** wholesalers who provide products **directly** to the patient/end user **are not required to be licensed in Georgia.**

- **Wholesalers:** Monthly transaction reports involving controlled substances are required by law to be maintained and in your possession. GDNA may request copies of these records at any time.

- **Which pages of the application do I submit?**

  Retail, Hospital, Retail/Home Health, and Retail PBM applicants submit pages **3, 4, 15, 16** and **17.**
  Nuclear Pharmacy applicants submit pages **3, 5, 15, 16** and **17.**
  Researcher applicants must submit pages **3, 6, 7, 15, 16** and **17.** Also, attach a brief resume and current photo (2x2 passport style photo).
  Opioid Treatment Clinic and **Outpatient Clinic** applicants submit pages **3, 8, 15, 16** and **17.**
  Prison Pharmacy applicants submit pages **3, 9, 15, 16** and **17.**
  Manufacturer applicants submit pages **3, 10, 13, 15, 16, 17, 18** and **19.**
  Wholesaler, Third-Party Logistic Providers and **Reverse Distributor** applicants submit pages **3, 11, 12, 13, 15, 16, 17, 18** and **19.**
  Remote Automated Medication System (RAMS) applicants submit pages **3, 14, 15, 16** and **17.**

- **All applications require a completed affidavit of applicant and appropriate secure and verifiable documents.**

- **When completing the application be sure to enter the name and license number of the existing license that you currently hold regardless of the change that is being made.**

- **If you are a 503B Outsourcing Facility, you need to complete the Manufacturing Application.**

Georgia Board of Pharmacy

2 MLK Jr. Drive, SE 11th Floor
East Tower
Atlanta, GA 30334

(404) 651-8000 www.gbp.georgia.gov

Do Not Write in this Section:
Receipt#: _____
Amount: _____
Applicant#: _____
Initials/Date: _____

APPLICATIONS ARE VALID FOR ONE YEAR

The fee for a name change is only $100.00. The fee for checks returned due non-sufficient funds is $30.00.

Purpose of Application:

License Type/Application Fee:

( ) Retail Pharmacy - $500.00 – (Georgia only)
( ) Hospital Pharmacy - $500.00 – (Georgia only)
( ) Retail/Home Health - $500.00 – (Georgia only)
( ) Retail/PBM - $500.00
( ) Researcher Pharmacy - $100.00
( ) Opioid Treatment Clinic - $500.00 – (Georgia only)
( ) Outpatient Clinic - $500.00 – (Georgia only)
( ) Prison Pharmacy - $500.00 – (Georgia only)
( ) Wholesaler - $1,000.00
( ) Third-Party Logistics Providers (3PL) - $1,000.00 – (Georgia only)
( ) Reverse Distributor - $1,000.00
( ) Manufacturer Pharmacy - $1,000.00
( ) Nuclear Pharmacy - $500.00
( ) Remote Automated Medication System(RAMS) - $500.00

Purpose of Application:

( ) New Registration
( ) Reinstatement - $350.00 + late renewal fee for each renewal period missed
( ) Change of Ownership (Same as application fee)
( ) Change in Location (Same as application fee)
( ) Change in Primary Person in Charge (Researcher's only) - $100.00
Name: _____
( ) Change in Facility Name - $100.00
Previous Name: _____
Current License Number: _____

Location of Facility:

( ) **IN** Georgia ( ) **OUTSIDE** Georgia

Affiliation:

Name or title under which business is conducted: Emory University
(Please list legal name and dba name) (include dba between the two)

Physical Address: 123 Main Street, Main Building, Room #4567, Atlanta, GA 30322, Dekalb County
(P.O. Box not acceptable) Number and Street City/State Zip (Researcher include Bldg Nm & Room #) County

Mailing Address: Same as above
(If different) Number and Street City/State Zip

(###)###-#### **Employer Identification Number:** 58-0566256
Telephone Number (Day)

Give the name, address and title of contact person to whom the Board may contact regarding the application only:

Name: Researcher Name **Title:** Title

Address: Mailing or Physcial Address from above

Phone#: Researcher Number **Email Address:** Researcher email address

Acknowledgement of your application 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 application 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 regard to this application.

Please list the date the Change of Name, Change of Location, or Change of Ownership Will Be Effective:

If applicable

RETAIL, HOSPITAL, RETAIL/HOME HEALTH, AND RETAIL PBM APPLICANTS COMPLETE THIS PAGE

1. Type of Ownership: ( ) Individual ( ) Partnership ( ) Corporation ( ) Government ( ) LLC

Name of Pharmacist in Charge: _____ License No: _____

2. Owner's Name: _____
(If a partnership, list names of **all** partners; if a corporation, list names and titles of **all** corporate officers. Use additional paper if additional space is needed).

3. Name of other registered pharmacists regularly and actively employed in the pharmacy or drug store (attach additional paper if additional space is needed).

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

4. Do you have a Class A Balance and other equipment as required in Board Rule 480-10-.12?
( ) Yes ( ) No – *PBM's are exempt.*

5. Does the store keep an exempt narcotics register? **( ) Yes ( ) No – *PBM's are exempt.***

6. Are narcotics stored or locked in a secure place? **( ) Yes ( ) No –** Mixed with stock? **( ) Yes ( ) No – *PBM's are exempt.***

7. Does the store keep a poison register? **( ) Yes ( ) No – *PBM's are exempt.***

8. Date the pharmacy will be open for business: _____

9. Have any of the owners, partners of the firm, or officers of the corporation ever been convicted of any crime under the laws of the United States, Georgia, or any other state pertaining to the manufacturing, distribution, sale or dispensing of drugs or narcotics? **( ) Yes ( ) No (If yes, please attach an explanation and have certified documents sent to the Board office.)**

10. Do you have safeguards to prevent the sale or other distribution of dangerous drugs, prescription drugs, or narcotics to any person other than: Practitioners of the healing arts, registered drug wholesalers, distributors or suppliers, licensed pharmacists, licensed pharmacies, or carriers/warehousemen (for the purpose of carriage or storage)? **( ) Yes ( ) No**

11. Type of drugs you distribute or wish to distribute: ( ) Dangerous Drugs (Legend Drugs) ( ) Controlled Substances

12. Do you understand that every drug wholesaler or reverse distributor registered with the Georgia State Board of Pharmacy is required to submit reports of excessive purchases of controlled substances with the Federal Drug Enforcement Administration and shall be required to submit a copy of each report to the Georgia Drugs and Narcotics Agency? **( ) Yes ( ) No Please Note:** The report requirements do not apply to any wholesalers, manufacturers, or reverse distributors who only ship controlled substances directly to a licensed wholesaler within the State of Georgia.

13. Will this pharmacy use sterile preparations in compounding prescriptions? **( ) Yes ( ) No**

Give the name, address, and title of the person to whom notices and citations may be served from the Board.

Name: _____ Title: _____

_____
Street Address City State Zip

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed during the period any permit issued may be in force and effect.

Sworn to and subscribed before me this _____day of _____, _____.

_____
Notary Public/Expiration Date of Commission/Seal
NOTARY SIGNATURE & SEAL REQUIRED

Firm Name: _____
Applicant Signature: _____
By: _____
(State whether individual owner, Partner or Officer of the Corporation)
Date: _____

NUCLEAR PHARMACY APPLICANTS COMPLETE THIS PAGE

1. Name/License Number of Nuclear Pharmacist-in-Charge: _____

2. Name/License Numbers of other pharmacists and nuclear pharmacists to be employed in the pharmacy:

Pharmacists:		Nuclear Pharmacists:	
(Name)	(License #)	(Name)	(License #)
(Name)	(License #)	(Name)	(License #)

3. Do you have the equipment as required under Rule 480-25-.08? **( ) Yes ( ) No**

4. Has an application for radioactive materials license been submitted to the Georgia Department of Natural Resources? **( ) Yes ( ) No** Date submitted: _____

5. Please furnish the information requested in subsections (A), (B), (C), (D), and (E) for each individual owner, all members of the partnership, and all officers of a corporation having less than twenty-six (26) stockholders. In addition, this information must be furnished for:
   - All Stockholders if applicant is a corporation with five (5) or fewer stockholders;
   - One-half (1/2) the stockholders, if the applicant is a corporation with between six (6) and twenty-six (26) stockholders;
   - Corporations having more than twenty-six (26) stockholders need only submit the requested information for the individuals owning more than twenty-five percent (25%) or more of the total stock.

(A) Name/Title: _____

(B) Have you ever been arrested, convicted, sentenced, pled guilty to, pled *nolo contendere* to, or given first offender status for the commission of a felony, misdemeanor, or any offense other than a minor traffic violation? (DWI & DUI's are **not** minor traffic violations.) **( ) Yes ( ) No (If yes, please attach an explanation and have the certified documents sent to the Board office.)**

(C) Have you ever had any restrictions as a Medicaid or Medicare Provider? **( ) Yes ( ) No (If yes, please attach an explanation and have the certified documents sent to the Board office.)**

(D) Have you ever had revoked or suspended or otherwise sanctioned any license issued by any Board or agency in Georgia or in any other State? **( ) Yes ( ) No (If yes, please attach an explanation.)**

(E) Have you ever been denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license by any Board or agency in Georgia or any other State? **( ) Yes ( ) No (If yes, please attach an explanation.)**

Give the name, address, and title of the person to whom notices and citations may be served from the Board.

Name: _____ Title: _____

_____

Street Address City State Zip

The undersigned hereby swears, or affirms, that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon, will be faithfully observed during the period any permit issued may be in force and effect.

Sworn to and subscribed before me this _____ day of _____, _____.

_____

Notary Public/Expiration Date of Commission/Seal

NOTARY SIGNATURE & SEAL REQUIRED

Firm Name: _____

Applicant Signature: _____

By: _____

(State whether individual owner, Partner or Officer of the Corporation)

Date: _____

RESEARCHER APPLICANTS COMPLETE THIS PAGE

(Registration for those who plan to obtain, possess, or conduct research, teaching, analysis or drug dog detection/training with controlled substances)

Name of primary individual in charge/responsible for protocol: Researcher Name

License Number (if applicable): not applicable for new applicants

1. List the drugs (generic names) and the controlled substance schedule numbers that will be used:

List all controlled substances and dangerous drugs that are listed on the procotol. Please visit the ORIC website for a complete list of CS/DD or contact ORIC@emory.edu for a spreadsheet.

2. List the approximate amount of drugs to be used per year: list approximate amounts per year.Addt'l page may be necessary

3. Provide a brief description of the protocol for this program:

Provide a brief summary of the protocol for which the drugs will be used.

4. From where will the controlled substances utilized in this program be obtained? Emory Express or ...

5. Brief description of the security procedures to be used to secure controlled substances used in this program:

Describe the cabinet/safe and room where the drugs will be stored. Be sure to include the security measures required to access the room.

(ATTACH CURRENT PHOTO HERE)

RESEARCHER APPLICANTS COMPLETE THIS PAGE

(Registration for those who plan to obtain, possess, or conduct research, teaching, analysis or drug dog detection/training with controlled substances)

PERSONAL DATA SHEET

All persons in charge/responsible for the protocol of the program must complete this form. Attach a brief resume or curriculum vitae of scientific education and/or training and/or degrees. Include present and former employers within the past ten years, giving address of each and date of employment. (If law enforcement agency, submit copies of training certificates pertaining to drug dog handling.) Also, attach evidence of US citizenship or eligible alien status under the Work Opportunity and Person Responsibility Act of 1996.

1. _____ Title: _____
(Last) (First) (Middle)

2. _____
Street Address City State Zip

3. _____ _____
(Date of Birth) (Social Security Number*)

***This information is authorized to be obtained and disclosed to state and federal agencies pursuant to O.C.G.A. §19-11-1 and O.C.G.A §20-3-295, 42 U.S.C.A. §551 and 20 U.S.C.A. §1001. It may also be disclosed to the National Practitioner's Databank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) or other licensing boards, or other regulatory agencies for license tracking purposes.**

4. Have you ever been arrested, convicted, sentenced, pled guilty to, pled *nolo contendere* to, or given first offender Status for the commission of a felony, misdemeanor, or any offense other than a minor traffic violation? (DWI & DUI's are **not** minor traffic violations.) **( ) Yes ( ) No (If yes, please attach an explanation and have certified documents sent to the Board office.)**

5. Have you ever had a research permit issued by any State, Federal, or local government revoked, suspended, or Otherwise sanctioned? **( ) Yes ( ) No (If yes, provide certified copies of the official documents pertaining to this matter.)**

6. **Please initial the following statement indicating your acknowledgement:**

I am aware that the above information is in connection with application to obtain, possess, or conduct research with controlled substances and the furnishing of false or misleading information in such matters is a felony under Georgia Law. I hereby authorize the Georgia State Board of Pharmacy to receive any criminal history information pertaining to me which may be in the files of any local, State, or Federal criminal justice agency. _____(Initials)

Give the name, address, and title of the person to whom notices and citations may be served from the Board.

Name: _____ Title: _____

_____
Street Address City State Zip

AFFIDAVIT

I swear that all statements made on the application for registration and personal data sheet are true and correct and that all provisions of the law and regulations pertaining to this registration will be faithfully observed during the period of time any license may be in force and effect.

Sworn to and subscribed before me this _____ day _____ _____
_____, _____. (Applicant Signature) (Date)

_____
Notary Public/Expiration Date of Commission/Seal
NOTARY SIGNATURE & SEAL REQUIRED

OPIOID TREATMENT CLINIC AND OUTPATIENT CLINIC APPLICANTS COMPLETE THIS PAGE

Type of Ownership: ( ) Individual ( ) Partnership ( ) Corporation ( ) Government ( ) LLC

DO NOT DO THIS PAGE

Please furnish the information requested in subsections (A), (B), (C), (D), and (E) below for each individual owner, all members of a partnership, and all officers and directors of a corporation having less than twenty-six (26) stockholders.

Name/License Number of Director of Pharmacy: _____

In addition, this information must be furnished for:

- All stockholders if applicant is a corporation with five (5) or fewer stockholders;
- One-half (1/2) of the stockholder, if applicant is a corporation with between six (6) and twenty-six (26) stockholders;
- Corporations having more than twenty-six (26) stockholders need only submit the requested information for individuals owning twenty-five percent (25%) or more of the total stock.

(A) Name _____
(Indicate whether individual owner, partner, officer, director, and percentage of stock owned)

Home Address _____
Street Address City State Zip

(B) Have you ever been arrested, convicted, sentenced, pled guilty to, pled *nolo contendere* to, or given first offender status for the commission of a felony, misdemeanor, or any offense other than a minor traffic violation? (DWI & DUI's are **not** minor traffic violations.) **( ) Yes ( ) No (If yes, please attach an explanation and have the certified documents sent to the Board office.)**

(C) Have you ever had any restrictions as a Medicaid or Medicare provider? **( ) Yes ( ) No (If yes, please attach an Explanation.)**

(D) Have you ever had revoked or suspended or otherwise sanctioned any license issued by any Board or agency in Georgia or in any other State? **( ) Yes ( ) No (If yes, please attach an explanation.)**

(E) Have you ever been denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license by any Board or agency in Georgia or any other State? **( ) Yes ( ) No (If yes, please attach an explanation.)**

Give the name, address, and title of the person to whom notices and citations may be served from the Board.

Name: _____ Title: _____

_____
Street Address City State Zip

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed during the period any permit issued may be in force and effect.

Sworn to and subscribed before me this _____ day of _____, _____.

_____
Notary Public/Expiration Date of Commission/Seal
NOTARY SIGNATURE & SEAL REQUIRED

Firm Name: _____
Applicant Signature: _____
By: _____
(State whether individual owner, Partner or Officer of the Corporation)
Date: _____

PRISON PHARMACY APPLICANTS COMPLETE THIS PAGE

Name of Director of Pharmacy: _____ License #: _____

1. Names of other registered pharmacists regularly and actively employed in the pharmacy:

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

2. List hours of operation: _____

3. Do you have written policies and procedures for the absence of a pharmacist as required by Board Rule 480-8-.04?
( ) Yes ( ) No

4. Do you have the minimum equipment as required by Board Rule 480-8-.05 entitled "Physical Requirements"?
( ) Yes ( ) No

5. Is there controlled drug storage for Schedule II drugs? **( ) Yes ( ) No**

6. Date pharmacy will be open for business: _____

7. Has the Director of Pharmacy or any of the pharmacists ever been arrested, convicted, sentenced, pled guilty to, pled *nolo contendere* to or given first offender status for the commission of a felony, misdemeanor or any offense other than a minor traffic violation? (DWI & DUI's are **not** minor traffic violations.) **( ) Yes ( ) No (If yes, please attach an explanation and have certified documents sent to the Board office.)**

8. Has the Director of Pharmacy or any of the pharmacists ever had any restrictions as a Medicaid or Medicare provider?
( ) Yes ( ) No (If yes, please attach an explanation.)

9. Has the Director of Pharmacy or any of the pharmacists ever had revoked or suspended or otherwise sanctioned any license issued by any Board or Agency in Georgia or in any State? **( ) Yes ( ) No (If yes, please attach an explanation and have certified documents sent to the Board office.)**

10. Has the Director of Pharmacy or any of the pharmacists ever been denied licensure of or, pursuant to disciplinary Proceedings, refused renewal of a license by any Board or Agency in Georgia or any other State?
( ) Yes ( ) No (If yes, please attach an explanation.)

11. Will this pharmacy do sterile compounding? **( ) Yes ( ) No**

Give the name, address, and title of the person to whom notices and citations may be served from the Board.

Name: _____ Title: _____

_____
Street Address City State Zip

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed during the period any permit issued may be in force and effect.

Sworn to and subscribed before me this _____ day of _____, _____.

_____
Notary Public/Expiration Date of Commission/Seal
NOTARY SIGNATURE & SEAL REQUIRED

Firm Name: _____
Applicant Signature: _____
By: _____
(State whether individual owner, Partner or Officer of the Corporation)
Date: _____

MANUFACTURER PHARMACY APPLICANTS COMPLETE THIS PAGE

1. Type of Ownership: ( ) Individual ( ) Partnership ( ) Corporation ( ) LLC

State of Incorporation (if applicable): _____

2. Names of Owners: If additional space is needed, use additional paper.

_____ _____
(President's Name) (Address)

_____ _____
(Vice President's Name) (Address)

_____ _____
(Secretary/Treasurer's Name) (Address)

Previous trade, corporate, or partnership names (if any) and addresses: _____

_____

3. Have you ever had revoked or suspended or otherwise sanctioned any license issued by any Board or Agency in Georgia or in any other State? **( ) Yes ( ) No (If yes, please attach an explanation and have certified copies of all documents and records sent to the Board office.)**

4. Have you ever been denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license by any Board Or Agency in Georgia or any other State? **( ) Yes ( ) No (If yes, please attach an explanation and have certified copies of all documents and records sent to the Board office.)**

Scientific and Technical Personnel:

(A) Names of registered pharmacist employees: _____

(B) Names of chemist employees: _____

(C) State details of the scientific and technical training of individuals listed above, name colleges attended and degrees held by those supervising the manufacturing covered by this application: _____

_____

Give the name, address, and title of the person to whom notices and citations may be served from the Board.

Name: _____ Title: _____

_____

Street Address City State Zip

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed during the period any permit issued may be in force and effect.

Sworn to and subscribed before me this _____ day of _____, _____.

_____

Notary Public/Expiration Date of Commission/Seal

NOTARY SIGNATURE & SEAL REQUIRED

Firm Name: _____

Applicant Signature: _____

By: _____

(State whether individual owner, Partner or Officer of the Corporation)

Date: _____

WHOLESALER, THIRD-PARTY LOGISTIC PROVIDER (In-State Only) AND REVERSE DISTRIBUTOR APPLICANTS COMPLETE THIS PAGE

1. Type of Ownership: ( ) Individual ( ) Partnership ( ) Corporation ( ) LLC

State of Incorporation (if applicable): _____

2. Names of Owners: If additional space is needed, use additional paper.

_____ _____

(President's Name) (Address)

_____ _____

(Vice President's Name) (Address)

_____ _____

(Secretary/Treasurer's Name) (Address)

3. List the state(s) in which the facility(s) is located that will be supplying drugs to Georgia:

_____

4. Which of the above-mentioned state(s) require licensure of Wholesalers or Reverse Distributors?

_____

(The enclosed certification of licensure form **MUST BE** completed by each of the above state(s) or verification of licensure pulled from the state board's website and submitted with this application.)

5. Have you ever had a revoked, suspended, or otherwise sanctioned license issued by any Board or Agency in Georgia or any other State? **( ) Yes ( ) No (If yes, please attach an explanation and have certified copies of all documents and records sent to the Board office.)**

6. Have you ever been denied issuance of, or pursuant to disciplinary proceedings, refused renewal of a license by any Board or Agency in Georgia or any other State? **( ) Yes ( ) No (If yes, please attach an explanation and have certified copies of all documents and records sent to the Board office.)**

7. Have any of the owners, partners of the firm, or officers of the corporation ever been convicted of any crime under the laws of the United States, Georgia, or any other State pertaining to the manufacturing, distribution, sale or dispensing or drugs or narcotics? **( ) Yes ( ) No (If yes, please attach an explanation and have certified copies of all documents and records sent to the Board office.)**

8. Do you have safeguards to prevent the sale or other distribution of dangerous drugs, prescription drugs, or narcotics to any person other than: Practitioners of the healing arts, registered drug wholesalers, distributors or suppliers, licensed pharmacists, licensed pharmacies, or carriers/warehousemen (for the purpose of carriage or storage)? **( ) Yes ( ) No**

Researcher Numbrerr

9. Type of drugs you distribute or wish to distribute: ( ) Dangerous Drugs (Legend Drugs) ( ) Controlled Substances

10. Do you understand that every drug wholesaler or reverse distributor registered with the Georgia State Board of Pharmacy is required to submit reports of excessive purchases of controlled substances with the Federal Drug Enforcement Administration and shall be required to submit a copy of each report to the Georgia Drugs and Narcotics Agency? **( ) Yes ( ) No**
Please Note: The report requirements for question #10 do not apply to any wholesalers, manufacturers, or reverse distributors who only ship controlled substance directly to a licensed wholesaler within the State of Georgia.

WHOLESALER, THIRD-PARTY LOGISTIC PROVIDER, AND REVERSE DISTRIBUTOR APPLICANTS COMPLETE THIS PAGE

Give the name, address, and title of the person to whom notices and citations may be served from the Board.

DO NOT DO THIS PAGE

Name: _____ Title: _____

_____

Street Address City State Zip

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed during the period any permit issued may be in force and effect.

Sworn to and subscribed before me this _____ day of _____, _____.

_____

Notary Public/Expiration Date of Commission/Seal

NOTARY SIGNATURE & SEAL REQUIRED

Firm Name: _____

Applicant Signature: _____

By: _____

(State whether individual owner, Partner or Officer of the Corporation)

Date: _____

MANUFACTURER, WHOLESALER, and REVERSE DISTRIBUTOR APPLICANTS COMPLETE THIS PAGE

CERTIFICATION OF LICENSURE AS A
MANUFACTURER, WHOLESALER, OR REVERSE DISTRIBUTOR

DO NOT DO THIS PAGE

This certification form must be completed by the State Licensing Board for each State in which a license is held and returned to the applicant to submit with the Georgia State Board of Pharmacy licensing application.

This is to certify that _____ was issued

license number _____ on ____/____/____ to operate as a

(circle one) manufacturer, wholesaler, or reverse distributor in the State of _____.

This is to further certify that the above-named manufacturer, wholesaler, distributor, or supplier's license is current and in good standing and that there have never been any sanctions against the holder's license.

This, _____ day of _____, _____.

_____ _____
(Print Name) (Signature)

_____
(Title)

_____
(Complete Name of Board)/Seal

REMOTE AUTOMATED MEDICATION SYSTEM (RAMS) APPLICANTS COMPLETE THIS PAGE

Name of Pharmacy making application for this RAMS: _____

Pharmacy License Number: _____

DO NOT DO THIS PAGE

Name of Pharmacist-in-Charge: _____ License #: _____

Pharmacy Owner's Name: _____
(If a partnership, list names of **all** partners; if a corporation, list names and titles of **all** corporate officers. Use additional paper if additional space is needed.)

1. Has any owner of this pharmacy ever been arrested, convicted, sentenced, pled guilty to, pled *nolo contendere* to, or given first offender status for the commission of a felony, misdemeanor, or any offense other than a minor traffic violation? (DWI & DUI's are **not** minor traffic violations.) **( ) Yes ( ) No (If yes, please attach an explanation and have the certified copies of all documents and records sent to the Board office.)**

2. Has this pharmacy ever had any restrictions as a Medicaid or Medicare Provider? **( ) Yes ( ) No (If yes, please attach an explanation and have the certified copies of all documents and records sent to the Board office.)**

3. Has the pharmacy ever had revoked or suspended or otherwise sanctioned any license issued by any Board or Agency in Georgia or in any other State? **( ) Yes ( ) No (If yes, please attach an explanation.)**

4. Has this pharmacy ever been denied issuance of or, pursuant to disciplinary proceedings, refused renewal of a license by any Board or Agency in Georgia or any other State? **( ) Yes ( ) No (If yes, please attach an explanation.)**

5. Does this pharmacy have a policy and procedure manual at the skilled nursing facility or hospice that includes all of the requirements for Board Rule 480-37-.03(a)? **( ) Yes ( ) No**

6. Does the applicant agree to comply with all laws and rules for the Georgia State Board of Pharmacy, including all of the rules for RAMS included in Rule 480-37? **( ) Yes ( ) No**

Give the name, address, and title of the person to whom notices and citations may be served from the Board.

Name: _____ Title: _____

_____

Street Address City State Zip

The undersigned hereby swears, or affirms that all statements made herein are true and correct, and that all the provisions of the law and regulations based thereon will be faithfully observed during the period any permit issued may be in force and effect.

Sworn to and subscribed before me this _____ day of _____, _____.

_____
Notary Public/Expiration Date of Commission/Seal
NOTARY SIGNATURE & SEAL REQUIRED

Firm Name: _____
Applicant Signature: _____
By: _____
(State whether individual owner, Partner or Officer of the Corporation)
Date: _____

AFFIDAVIT OF APPLICANT

I hereby swear and affirm that all information provided in this application is true and correct to the best of my knowledge and belief. I further swear and affirm that I have read and understand the current state laws and rules and regulations of the Georgia State Board of Pharmacy and I agree to abide by these laws and rules, as amended from time to time.

By signing this application, electronically or otherwise, I hereby, swear and affirm one of the following to be true and accurate pursuant to O.C.G.A. §50-36-1:

1. _____ I am a United Sates citizen 18 years of age or older. Please submit a copy of your current Secure and Verifiable Document(s) such as driver's license, US passport, or document as indicated on pages 16 & 17 of this application.

2. _____ I am not a United States citizen, but I am a legal permanent resident of the United States 18 years of age or older, or I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act 18 years of age or older with an alien number issued by the Department of Homeland Security or other federal immigration agency. Please submit a copy of your current immigration document(s) which includes either your Alien number or your I-94 number and if needed, SEVIS number.

In making the above attestation, I understand that any failure to make full and accurate disclosures may result in disciplinary action by the Georgia State Board of Pharmacy and/or criminal prosecution.

_____

Print Applicant's Name

_____ _____

Signature of Applicant Date

Personally appeared before me, the undersigned official authorized to administer oaths, comes

Researcher Name _____ who deposes and swears that he/she is the person who executed this
(Applicant's Name)

application for a pharmacy license, permit, or registration in the State of Georgia; and that all of the statements herein

contained are true to the best of his/her knowledge and belief.

Sworn to and subscribed before me this _____ day of _____, _____.

Notary Public Signature: _____

_____

County State

My Commission Expires: _____

(seal)

NOTARY SIGNATURE & SEAL REQUIRED

APPLICANT: PLEASE CHECK THE FORM OF IDENTIFICATION BELOW THAT YOU POSSESS. RETURN THIS FORM ALONG WITH A COPY OF YOUR APPROPRIATE DOCUMENTATION. ONLY ONE DOCUMENT REQUIRED, DO NOT SEND YOUR ORIGINAL.

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued February 20, 2018, by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA"), as amended by Senate Bill 160, signed into law as Act No. 27, (2013), provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(g). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- ☐ An unexpired United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- ☐ An unexpired United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- ☐ An unexpired driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2][1]
- ☐ An unexpired identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

[1] For identification presented to poll workers when voting, a registered Georgia voter may present an expired Georgia driver's license as proof of identification when voting pursuant to O.C.G.A. § 21-2-417.

☐ An unexpired tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be accessed at: https://www.bia.gov/tribal-leaders-directory [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ An unexpired United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ An unexpired Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ An unexpired passport issued by a foreign government, provided that such passport is accompanied by a United States Department of Homeland Security ("DHS") Form I-94, DHS Form I-94A, DHS Form I-94W, or other federal form specifying an individual's lawful immigration status or other proof of lawful presence under federal immigration law[2] [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ An unexpired Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ An unexpired Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

☐ An unexpired NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

☐ An unexpired Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

☐ An unexpired driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

☐ A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

[2] Senate Bill 160 (Act No. 27), effective July 1, 2013, limited the use of passports issued by foreign nations to satisfy the requirements for submission of secure and verifiable documents to only those passports submitted in conjunction with a United States Department of Homeland Security ("DHS") Form I-94, DHS Form I-94A, DHS Form I-94W, or other federal form specifying an individual's lawful immigration status or other proof of lawful presence under federal immigration law.

PLEASE MAIL DIRECTLY TO:
Georgia Drugs and Narcotics Agency
254 Washington Street SW Ste G2000
Atlanta, GA 30334
404-656-5100 / 800-656-6568 / fax: 404-651-8210

DO NOT DO THIS PAGE

PERSONNEL CERTIFICATION FORM

For All persons applying for a Georgia State Board of Pharmacy Facility

Instructions: ***PLEASE RETURN ORIGINAL FORM TO ADDRESS LISTED ABOVE***

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

This form should be completed by each person named in the application as an owner of the firm, including the President/CEO, Vice President, Secretary/Treasurer, the Pharmacist-in-Charge and the individual who is the company's contact person for the Board and GDNA. For larger corporations with multiple divisions and officers, please limit the contact personnel to 5 individuals, including the President/CEO, Vice Presidents and/or others directly responsible for drug acquisition and distribution, and the responsible person for contact with the Georgia State Board of Pharmacy and GDNA.

When an application is filed for a change of ownership, each new officer (or responsible officer) must complete the 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 application. This information will be used to determine your qualifications for registration and licensure under the Georgia Pharmacy Law. This information may be shared with other government agencies upon receipt of an official request.

Applicant Name: _____ **Sex:** _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Social Security #:** _____

Contact Telephone: _____ **Contact Fax:** _____

Email Address: _____

Firm Name: _____

Position or Title: _____

On the following questions, please check the appropriate Yes or No box for each of the following questions:(You may attach a written explanation providing complete information if needed.)

Failure to provide an explanation will delay the application process.

This form must be notarized and mailed to the GDNA Office at the address listed on page 1. Please do **not** email.

PERSONNEL CERTIFICATION FORM – Page 19

Licensure – (Must include present and previous work and ownership history for at least 20 years)	
1. 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?	☐Yes ☐No
a) If yes, please list the name of the firm, complete address, and date(s) of ownership and/or employment. (attach sheet(s) if necessary)	
b) If no, please explain your relationship with the firm listed on the application. (attach sheet(s) if necessary)	
2. Are you currently, or have you ever been licensed as a pharmacist? If yes, please list the state(s) where you have been licensed and the license number(s).	☐Yes ☐No
3. Have you ever had, or been associated with a personal or firm's professional license that has been denied, suspended, revoked, or sanctioned by this or any other state or federal governmental authority? If yes, please attach an explanation.	☐Yes ☐No
4. 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. If yes, please attach an explanation.	☐Yes ☐No
5. 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? If yes, please attach an explanation.	☐Yes ☐No

DO NOT DO THIS PAGE

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. I understand if false, inaccurate, or misleading information is provided on this document, the Georgia State Board of Pharmacy (Board) may refuse to issue or renew any facility license 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, if applicable, 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 _____,_____

_____ My Commission Expires: _____

Signature of Notary Public

NOTARY SIGNATURE & SEAL REQUIRED

This form must be notarized and mailed to the GDNA Office at the address listed on page 1. Please do **not** email.