

This area for ASBP date stamp

Arizona State Board of Pharmacy

1700 W. Washington Street, Room 250, Phoenix, AZ 85007

APPLICATION FOR PHARMACY PERMIT (Call Board Office for Fee Information)

Please check appropriate type of operation: Chain Hospital Independent Limited Service

1. Business name: _____
2. Address: _____
Street and Number City State Zip
3. Phone: _____ FAX: _____ E-mail _____
4. Mailing address if different: _____
Street and Number City State Zip
5. Name of owner(s): _____ Phone: _____ FAX: _____
If corporation or partnership, attach a list officers or partners on a separate sheet including name, title and address.
6. Date business started/opening: _____
7. This application submitted because of change in ownership? No Yes . If yes; give former owner's name, AZ permit number, and permit name (if different) _____
8. Other trade or business names used: _____
9. Have you conducted a similar business in any other jurisdiction?
No Yes . If yes, state under what names, locations and permit number:

10. Has the owner, or any corporate officer or active partner ever been convicted of an offense involving moral turpitude, a felony offense, or any drug-related offense or has any currently pending felony or drug-related charges, and is so indicate charge, conviction date, jurisdiction, and location:

11. Has the owner, any corporate officer or active partner ever been denied a pharmacy permit in this state or any other jurisdiction?
No Yes . If yes, indicate where and when:

12. FACILITIES LOCATED IN ARIZONA the following is required:
 - a) Floor plan. Include plans or construction drawing showing facility size and security adequate for the proposed business.
 - b) Zoning. Include documentation of compliance with local zoning laws.
 - c) The following individuals will be present at the Arizona State Board meeting when application is submitted for approval:
 - i) person named in Number 5, if non pharmacist owner.
 - ii) person named in Number 14.
13. FACILITIES LOCATED OUTSIDE OF ARIZONA: Attach a photo copy of license/permit issued by State of domicile.
14. Name of Pharmacist in Charge: _____
AZ License number _____ Expiration date: _____ Emergency phone: _____

To the best of my knowledge and belief the foregoing application is true and current in all respects.

Signature of Owner, Corporate Officer or Manager

Title

Date