

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Board of Registration in Pharmacy
Division of Health Professions Licensure
239 Causeway Street, Suite 500, Boston, MA 02114

Tel: 617-973-0860
Fax: 617-973-0980
TTY : 617-973-0988

www.mass.gov/dph/boards/pharmacy

APPLICATION FOR CHANGE IN MANAGER OF A PHARMACY
Instructions and Checklist
Application

Instructions:

Use this application whenever there is a change in the pharmacist Manager of Record of a pharmacy or pharmacy department. Carefully read the instructions and checklist for completing the license application. All forms and documents must be submitted promptly whenever there is a change in manger of a pharmacy.

A corporation or partnership which owns a pharmacy or pharmacy department which is registered by the Board shall notify the Board, within ten working days, in writing, of the following:

- (a) any change in its Articles of Organization;
- (b) any change in its Foreign Corporate Certificate;
- (c) any change in the d/b/a name of the business accompanied by appropriate authorizing documentation;
- (d) any change in the names and addresses of its officers and/or directors, and/or in their positions;
- (e) unless the stock of the corporation is publicly traded, any change in the total amount of stock issued or, names and addresses of the stockholders and the kinds and amounts of stock which they respectively own.

Do not return the controlled substance registration with this application.

Checklist of items to be submitted:

_____ A notarized application form, fully completed and signed.

_____ A sworn statement confirming that a complete inventory of controlled substances in Schedules II, III, IV and V signed by the outgoing pharmacist Manager of Record and the incoming pharmacist Manager of Record has been taken and filed with the pharmacy's controlled substance records. In the event the outgoing pharmacist Manager of Record is unavailable due to death, serious illness, or termination for inappropriate handling of

controlled substances, a staff pharmacist may be authorized to sign the inventory, provided the Board is notified at the time the application is submitted why the staff pharmacist is signing the inventory.

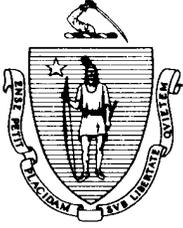
- _____ An application for a certificate of fitness (if applicable).
- _____ The original pharmacy permit and certificate of fitness, if applicable.
- _____ Required fee(s), check or money order payable to the Commonwealth of Massachusetts (\$525.00 for Change of Manager; \$180.00 for Certificate of Fitness, if applicable).
NOTE: Cash or foreign currency is not accepted. Fees are non-refundable and non-transferable.
- _____ Any additional information as determined by the Board.
- _____ Submission of completed applications and fees acknowledges that the applicant understands and agrees to all provisions herein.

A Compliance Inspection Report (available on the Boards website) should be completed by a PHARMACIST prior to submitting an APPLICATION FOR CHANGE IN MANAGER OF A PHARMACY to the Board and be kept on file at the pharmacy.

<http://www.mass.gov/eohhs/docs/dph/quality/boards/pharmacy/compliance-inspection-tool.pdf>

- _____ Retain a copy of the checklist, Compliance Inspection Report, completed applications and all additional documents for Change in Manager of a Pharmacy or Pharmacy Department for your records.

For complete information regarding regulations pertaining to a change in manager, please refer to 247 CMR 6.03(1). Board regulations may be found at www.mass.gov/dph/boards/ph. If additional information is needed, please contact the Board office at (800) 414-0168. **All fees are non-refundable and non-transferable.**



The Commonwealth of Massachusetts
 Executive Office of Health and Human Services
 Department of Public Health
 Board of Registration in Pharmacy
 Division of Health Professions Licensure
 239 Causeway Street, Suite 500, Boston, MA 02114

Tel: 617-973-0860
 Fax: 617-973-0980
 TTY : 617-973-0988

www.mass.gov/dph/boards/pharmacy

APPLICATION FOR CHANGE IN MANAGER
All Questions Must Be Completed

License Application Fee: \$525.00. Make check or money order payable to *Commonwealth of Massachusetts*. All fees are non-transferable and non-refundable

I hereby apply for a permit to operate a store for the transaction of retail drug business in accordance with the provisions of Chapter 112, General Laws.

1. Legal Name of Business. _____
2. Full Business Address (Street Address, City, State and Zip). _____

3. Pharmacy Phone. _____
 Pharmacy FAX _____ Pharmacy Email _____
4. All trade or business names (“D.B.A.” names) used by same Corporation or by Licensee. _____

5. Type of ownership or operation (i.e. sole proprietorship, partnership, corporation). _____

 If a corporation, please submit a copy of the Articles of Organization.
6. Name(s) and Social Security Number(s) of the owner(s) and/or operator(s) of the license.
 Please indicate type of ownership-*Partnerships*: the name of each partner and name and address of partnership; *Corporations*: the name and title of each corporate officer and director, the corporate names, name and address of parent company, if any, and the State of incorporation; *Sole Proprietorships*: the name of the sole proprietor and the name and address of the business entity. (Attach additional sheets if necessary) _____

7. Name of registered pharmacist previously charged with the management of the pharmacy.

8. Registration number of the previous manager. _____

9. Name of registered pharmacist who is applying to manage the pharmacy. _____

10. Registration number of the pharmacy manager applicant. _____

11. Name(s) and registration number(s) of staff pharmacist(s) employed at pharmacy. _____

12. A. Have any of the applicant(s) and/or managers-in-charge had: 1) any convictions related to the distribution of drugs (including samples); 2) any felony convictions; 3) any suspension(s) or revocation(s) or other sanction(s) by federal, state or local governmental agency of any license or registration currently or previously held by the applicant or licensee for the manufacture, distribution, or dispensing of any drugs, including controlled substances? ? Yes _____ No _____
If yes, provide a full explanation. (Attach additional sheets if necessary) _____

B. Have any applications for licensure been denied by any federal or state agency including any state boards of pharmacy? List and explain. (Attach additional sheets if necessary) _____

AFFIDAVIT (MUST BE SIGNED AND NOTARIZED)

Pursuant to M.G.L. c. 62C, s. 49A, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

The applicant certifies that each person employed in any prescription drug distribution activity has the education training, and experience, or any combination thereof, sufficient for that person to perform the assigned functions in such a manner as to provide assurance that the drug product quality, safety, and security will at all times be maintained as required by law.

I hereby state that I am the person authorized to sign this application for all licensure; that all statements are true and correct in all respects and are made under the penalties of perjury.

Signature of duly authorized representative
of the pharmacy or pharmacy department

Date

Social Security Number of the proposed Manager of Record

Sworn and subscribed before me this _____ day of _____

My commission expires _____

Name of Notary Public

NOTARY SEAL

WARNING:

In accordance with Chapter 94 M.G.L. Sec 13, the Board of Registration in Pharmacy in the case of a retail drug business or wholesale druggist, may suspend or revoke a registration to manufacture, distribute, dispense or possess a controlled substance after a hearing pursuant to the provisions of Chapter 34A and upon finding that the registrant has furnished false or fraudulent information in any application filed under the provisions of Chapter 94C.

RETAIN A COPY OF THIS APPLICATION AND CHECKLIST FOR YOUR RECORDS.

ALL FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE.

TO BE COMPLETED BY THE BOARD:

Check \$ _____ Date: _____ Number: _____