



STATE BOARD OF PHARMACY
 Department of Commerce, Community, and Economic Development
 Division of Corporations, Business and Professional Licensing
 Physical Address: 333 Willoughby Avenue, 9th Floor, Juneau, Alaska 99801
 Mailing Address: P.O. Box 110806, Juneau, Alaska 99811-0806
 Telephone: (907) 465-2589 ★ E-mail: license@alaska.gov

FOR OFFICE USE ONLY

**BIENNIAL PHARMACY, DRUG ROOM,
 WHOLESALE DISTRIBUTOR LICENSE RENEWAL**
 July 1, 2008 – June 30, 2010

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RENEWAL DUE DATE: The processing time for correct and complete renewal applications is three to four weeks after receipt. Plan accordingly and submit your renewal application by June 2, 2008, for renewal processing prior to June 30, 2008.

IT IS TIME TO RENEW YOUR PHARMACY, DRUG ROOM, WHOLESALE DISTRIBUTOR LICENSE

Your facility license in the State of Alaska expires on June 30, 2008. It is illegal for you to practice if your license has expired. THERE IS NO GRACE PERIOD. To renew your license for the period July 1, 2008 through June 30, 2010, return this completed and signed application along with the required documentation to the above address with a check or money order payable to the State of Alaska. This is the only renewal notice you will receive. Incomplete applications or insufficient fees will result in delayed or rejected renewals.

CHECK APPROPRIATE LICENSE BOX:

- Alaska Pharmacy – License #001 through #439 \$300.00
- Out-of-State Pharmacy – License #001 through #816 \$600.00
- Drug Room – License #01 through #41 \$300.00
- Wholesale Distributor – License #01 through #51 \$400.00

**MAKE CHECK OR MONEY
 ORDER PAYABLE TO THE
 STATE OF ALASKA.**

License Number _____

Name of Facility: _____

Corrected Business Mailing Address (complete only if mailing address is different than the address label shown above):

_____ Street/P.O. Box _____ City _____ State _____ Zip Code _____

Daytime Telephone Number: _____ Federal Employer Identification Number: _____

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

Name of Facility Manager for Wholesale Distributor or Consultant Pharmacist or Pharmacy for Drug Room:

Ownership of Pharmacy (check one): Sole Proprietorship* Partnership* Corporation

Names of Proprietors, Partners, or Corporate Officers: _____ *Social Security Numbers (Partners and owner)

NOTE: Licenses are nontransferable and any change of name, location or ownership will require a new license. Please contact the division for application forms. **Do not use this renewal application.**

List all registered pharmacists employed and license numbers:

Name of Pharmacist employed	License Number
_____	_____
_____	_____
_____	_____

PROFESSIONAL FITNESS: The following questions must be answered. "Yes" answers may not automatically result in license denial, however, you must explain dates and circumstances on a separate piece of paper and send any supporting documents that may be applicable (court records, license actions, etc.).

Since the date the facility license was last issued, has the owner or any partner, corporate officer, the pharmacist-in-charge or any employee

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. had a license denied, revoked, suspended, surrendered, placed on probation, or been the subject of any restriction, censure, reprimand or other disciplinary action in any jurisdiction? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. violated a federal, state, or local law relating to the practice of pharmacy, drug samples, wholesale or retail drug or device distribution, or distribution of controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. had a felony conviction under federal, state, or local law? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. furnished false or fraudulent material in an application made in connection with drug or device manufacturing or distribution? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. had a suspension or revocation by federal, state, or local government of a license currently or previously held for the manufacture or distribution of drugs or devices, including controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. obtained remuneration by fraud, misrepresentation, or deception? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. dealt with drugs or devices that are known or should have been known to be stolen drugs or devices? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. dispensed or distributed drugs or devices directly to patients by a wholesale drug distributor other than a pharmacy? | <input type="checkbox"/> | <input type="checkbox"/> |

★★ TO RENEW THIS LICENSE YOU MUST SUBMIT THE FOLLOWING DOCUMENTATION ★★

PHARMACIES, DRUG ROOMS, WHOLESALE DISTRIBUTORS: The Self-Inspection Report form (form enclosed).

OUT-OF-STATE PHARMACIES: A copy of the most recent Inspection Report completed within the immediate past two years and a copy of the current pharmacy license/registration from the jurisdiction where the facility is located. (If the Inspection Report was completed more than two years ago, you must complete the self-inspection report located at www.commerce.state.ak.us/occ/ppha.htm and submit it with this application.)

**FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY AND SUBMIT REQUIRED DOCUMENTATION
WILL RESULT IN THE LICENSE NOT BEING RENEWED**

By my signature below, I certify that the information furnished in this application is true and correct. I also certify that I have attached the required documentation listed above. (Note: For corporations, only persons authorized to sign on behalf of the corporation may sign this form.) *Warning: Any person who intentionally submits a false statement in this application is subject to prosecution under Alaska Statute.*

Signature of Owner or Officer _____ Title _____

Printed Name _____ Date _____

EXPIRED LICENSES – There is no "inactive" status. If you choose not to renew your license, it will lapse.

SOCIAL SECURITY NUMBER AND FEDERAL EMPLOYER IDENTIFICATION NUMBER – In accordance with Federal statutes, you must provide Social Security numbers for all owners and partners, and you must provide your Federal Employer Identification Number (FEIN).

PUBLIC INFORMATION – Please be aware that all information on this renewal form will be available to the public, unless required to be kept confidential by state or federal law. Information about current licensees, including mailing addresses, is available on the division's website at: <http://www.commerce.state.ak.us/occ> under "Professional License Search."

BUSINESS LICENSES – Renewal applications for business licenses are processed separately. For more information about business licenses, call (907) 465-2550 or access the website: www.commerce.state.ak.us/occbuslic.htm.

NEWSLETTER – The Board of Pharmacy publishes a quarterly newsletter. The newsletter may be viewed at: <http://www.commerce.state.ak.us/occ/ppha.htm>.

NOTIFICATION OF PROPOSED REGULATION CHANGES

If you would like to receive notice of all proposed State Pharmacy Board regulation changes, please send a written request adding your name to the Pharmacy Board Interested Parties List to:

REGULATIONS SPECIALIST
 Department of Commerce, Community, and Economic Development
 Division of Corporations, Business and Professional Licensing
 P.O. Box 110806
 Juneau, Alaska 99811-0806



State of Alaska
 Department of Commerce, Community, and Economic Development
 Division of Corporations, Business and Professional Licensing
 PO Box 110806, Juneau, Alaska 99811-0806
 Phone: (907) 465-2550
 Fax: (907) 465-2974

OFFICE USE ONLY

CREDIT CARD PAYMENT

For security purposes, please **do not email** credit card information. Fax or mail this form to the Division. Completion of this form is not proof of payment until the division processes the information contained herein. If any information on this form is illegible, the form will be rejected. Please print.

Name of Applicant or Licensee: _____
Corporate or Individual (first, middle, last)

License Number (if applicable): _____

Type of License: _____

I wish to make payment by credit card for the following:
(check all that apply)

- | | Amount |
|---|--------|
| <input type="checkbox"/> Application fee | _____ |
| <input type="checkbox"/> License (or renewal) fee | _____ |
| <input type="checkbox"/> Fine | _____ |
| <input type="checkbox"/> Other (specify): _____ | _____ |

Total: _____

Print Name on Credit Card: _____

Complete Mailing Address: _____

Telephone Number: _____

Signature of Credit Card Holder: _____

Credit Card Type (check one): VISA MASTERCARD

Card Number: _____

Please provide the 3-digit security code number from the back of the card: _____

Expiration Date: _____