



ARIZONA STATE BOARD OF PHARMACY
 P. O. Box 18520 Phoenix, AZ 85005
 p) 602-771-2727 f) 602-771-2749
 www.azpharmacy.gov

Application Received:	
Administrative Review:	
Substantive Review:	
Completeness Notice:	

FOR AGENCY USE ONLY

ASBP Approval:	License No.:	Fee:	Receipt No.:
Effective Date:	Certificate Mailed:	Check No.:	Check Date:
Fee From:	Fee To:		

101615

Application for Pharmacy Permit

INSTRUCTIONS

Pharmacies located within the state of Arizona will require floor plans or blueprints of the pharmacy area, a zoning statement, a copy of the lease, and must designate an Arizona licensed pharmacist as the Pharmacist in Charge (PIC).

Pharmacies located outside of Arizona will require a copy of the permit from their state of domicile.

APPLICABLE RULES AND STATUTES

Please familiarize yourself with the Rule(s) and/or Statute(s) listed below for more details about your permit.

Rules

R4-23-601, 602, 606 through 621
 R4-23-652 through 682

Statutes

A.R.S. § 32-1927.02, 1929, 1930, 1931, 1933, 1934
 A.R.S. § 32-1961 through 1977

BUSINESS INFORMATION

- Chain
- Hospital
- Independent
- Government
- Limited Service
- Non-Resident

Business Name

Street Address

City

County

State

Zip Code 99999 or 99999-9999

Phone

Ext

Fax

Email name@domain.com

ALTERNATE MAILING ADDRESS

Check if mailing address is the same as above address. If not, please enter it here.

Street Address

City

County

State

Zip Code 99999 or 99999-9999

OTHER BUSINESS INFORMATION

Indicate the date your business opened or will be opening.

Date started or opening

Other trade or business names used

SIMILAR BUSINESS

Have you conducted a similar business in any other state(s)? If yes, indicate under what names, locations and permit numbers. Please attach additional pages if more space is required.

Name

Street Address

City

State

Zip Code 99999 or 99999-9999

Permit Number

OWNER INFORMATION

Name or owner(s)

Phone

Ext

Fax

Do you have additional Officers or Partners? If yes, provide under what names and addresses.

Yes

No

If the business is a corporation or partnership, attach a list of officers or partners.

CHANGE IN OWNERSHIP

Is this application being submitted because of a change in ownership?

Yes No

If yes, indicate former owner's name, AZ permit number, and permit name.

Former Owner (full name)

Permit Number

Permit Name

OWNER OR OFFICER OFFENSES

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?

Yes No

If so indicate charge, conviction date, and location including city and state. Please attach additional pages if more space is required.

Offense Description

Has the owner, or any corporate officer or active partner ever been denied a permit in this or any other state?

Yes No

If yes, indicate where and when

Has any formal disciplinary action ever been taken against your pharmacy or any other professional license or certificate in any other states?

Yes No

If yes, indicate where and when

FACILITY INFORMATION

For facilities located in Arizona, attach the following:

- a) Floor plan. Include plans or construction drawing showing facility size and security adequate for the proposed business

The following individuals may be asked to appear at the Arizona State Board meeting when application is submitted for approval

- i) The person named in the above ownership section, if non pharmacist owned.
ii) The person named in the following Pharmacist in Charge section.

For facilities located outside of Arizona,

- a) attach a photocopy of your license/permit issued by your state of domicile.

PHARMACIST IN CHARGE (PIC) INFORMATION

Please fill in the following Pharmacist in Charge (PIC) information (Non-resident pharmacies do not require an Arizona licensed PIC).

Has the PIC been designated yet?

Yes No

Name of Pharmacist in Charge

License Number

Expiration Date

Street Address

City

County

State

Zip Code 99999 or 99999-9999

Emergency Phone

Ext

DESIGNATED REPRESENTATIVE INFORMATION

Do you want the Pharmacist in Charge to be the Designated Representative? If Yes, you may skip this section. If No, provide the Designated Representative's emergency phone number and home address information here.

Yes No

Name of manager or responsible person

Street Address

City

County

State

Zip Code 99999 or 99999-9999

Phone

Ext

ATTESTATION

I declare under penalty of perjury under the laws of the state of Arizona that the above information I have provided is true and correct to the best of my knowledge.

Signature

Date